Ref: MA/TH

To the Members of the Board of Directors of Dorset County Hospital NHS Foundation Trust

You are invited to attend a **public (Part 1) meeting of the Board of Directors** to be held on **26th January 2022** at **10.15am to 1.15pm** via MS Teams.

The agenda is as set out below.

Yours sincerely

Mark Addison
Trust Chair

AGENDA

1.	**FORMALITIES** to declare the meeting open.	Verbal	Mark Addison Trust Chair	Note	10.15-10.20
	a) Apologies for Absence: Patricia Miller	Verbal	Mark Addison	Note	
	b) Conflicts of Interests	Verbal	Mark Addison	Note	
	c) Minutes of the Meeting dated 24th November 2021	Enclosure	Mark Addison	Approve	
	d) Matters Arising: Action Log	Enclosure	Mark Addison	Approve	
2.	**Governance Update**	Enclosure	Mark Addison	Approve	10.20-10.40
3.	**CEO Update**	Enclosure	Nick Johnson	Note	10.40-10.50
4.	**Recovery Report** (Standing item)	Enclosure	Nick Johnson	Note	10.50-11.00
5.	**COVID-19 Update**	Verbal	Anita Thomas	Note	11.00-11.15
6.	**Performance Scorecard and Board Sub-Committee Escalation Reports** (December 21 and January 22) a) People and Culture Committee b) Quality Committee c) Finance and Performance Committee d) Risk and Audit Committee e) Charitable Funds Committee	Enclosure	Committee Chairs and Executive Leads	Note	11.15-11.40
7.	**ICS Development Update** including System Performance Update (Standing Item)	Verbal	Nick Johnson	Note	11.40-11.50
8.	**NED Board Champion Roles**	Enclosure	Mark Addison	Approve	11.50-12.00
Coffee Break 12.00-12.15					

9.	**Charitable Funds Finance Update**	Enclosure	Dave Underwood	Note	12.15-12.25
10.	**Board Assurance Framework and Risk Register** (January Risk and Audit Committee)	Enclosure	Nick Johnson Nicky Lucey	Note	12.25-12.35
11.	**Freedom to Speak Up Report** (November People and Culture Committee)	Enclosure	Ula Brocklebank	Note	12.35-12.45
12.	**Mortality Report** Appendices circulated separately and not to be published.	Presentation	Alastair Hutchison	Note	12.45-12.55
13.	**Maternity reports:** **a. Maternity Safety Report** (from Quality Committee) **b. Continuity of Carer Report** **c. Education and Training Report**	Enclosure	Nicky Lucey	Note	12.55-1.05
14.	**Questions from the Public**	Verbal	Mark Addison	Note	1.05-1.15
	CONSENT SECTION				-
	The following items are to be taken without discussion unless any Board Member requests prior to the meeting that any be removed from the consent section for further discussion.				
15.	**Charitable Funds Committee Terms of Reference**	Enclosure	Dave Underwood	Approve	
16.	**Any Other Business** Nil notified				
	Date and Time of Next Meeting				
	The next part one (public) Board of Directors' meeting of Dorset County Hospital NHS Foundation Trust will take place at **8.30am** on **Wednesday 30th March 2022** via MS Teams.				

Minutes of a public meeting of the Board of Directors of Dorset County NHS Foundation Trust held at 08.30am on 24th November 2021 via MS Teams videoconferencing.

Present:		
Mark Addison	MA	Trust Chair (Chair)
Sue Atkinson	SA	Non-Executive Director
Margaret Blankson	MB	Non-Executive Director
Judy Gillow	JG	Non-Executive Director
Paul Goddard	PG	Chief Financial Officer
Dawn Harvey	DH	Chief People Officer
Alastair Hutchison	AH	Chief Medical Officer
Nick Johnson	NJ	Deputy Chief Executive
Nicky Lucey	NL	Chief Nursing Officer
Ian Metcalfe	IM	Non-Executive Director
James Metcalfe	JM	Divisional Director
Stephen Slough	SS	Chief Information Officer
Anita Thomas	AT	Interim Chief Operating Officer
Stephen Tilton	ST	Non-Executive Director
David Underwood	DU	Non-Executive Director
In Attendance:		
Trevor Hughes	TH	Head of Corporate Governance *(Minutes)*
Abigail Baker	AB	Governance Support Officer *(observing)*
Heather Case	HC	Business Intelligence *(Item BOD21/076)*
Jordan La Page	JLP	Health Care Support Worker *(Staff Story)*
Elaine Hartley	EHa	Head of Education *(Staff Story)*
Emma Hoyle	EH	Acting Deputy Chief Nurse *(Item BOD21/081)*
Simon Pearson	SP	Head of Charity and Social Value *(Item BOD21/079)*
Natalie Violet	NV	Corporate Business Manager
James Woodland	JW	Business Intelligence *(Item BOD21/076)*
Members of the Public:		
Simon Bishop	SB	DCHFT Public Governor
Zarah Abbas	ZA	PriceWaterhouseCoopers
John Morris	JMo	PriceWaterhouseCoopers
Apologies:		
Richard Sim	RS	Divisional Director

BoD21/065	**Staff Story**	
	DH introduced JLP to the Board explaining that JLP had recently joined the trust working as a Health Care Support Worker (HCSW) on Evershot ward. He had joined the trust having had no previous care experience and would outline his experiences in order that learning could be applied to making future improvements for this group of staff. JLP explained his background and lack of satisfaction in previous Pre-NHS roles. The NHS provided job security and working with people was an important factor in his career choice. The HCSW role also provided him with an entry route to becoming a qualified nurse. JLP had progressed well since joining the trust, mentoring other HCSW staff and he had been supported in gaining further qualifications. His experiences of the trust had been positive overall and provided clear career progression opportunities, although delays in the recruitment	

	process had been extensive and disheartening and the level of communication from the trust during this period could have been improved. JLP added that at ward level, improvements could be made to ensure the consistent performance of some staff and promote accountability through greater delegation of responsibilities. Consideration to the development of a senior HCSW role could be considered to strengthen this. The Board thanked JLP for his clear and well-structured presentation and acknowledged the need to ensure ward managers were supported to address issues of performance. JLP added that people often did not have the confidence to speak up and that it could be further emphasised to new starters at induction, that staff were able to speak up without fear of detriment. In response to a question regarding educational support from the trust, JLP explained the need for greater promotion of the internal opportunities available to staff as he had not been aware of some opportunities that he was currently pursuing externally. DH explained that some elements of the recruitment process took considerable time and apologised for the delays that JLP had experienced. She acknowledged that locally operated systems and processes could be improved. The People and Culture Committee recognised the important contribution the HCSW staff group made and the need to focus on recruitment, onboarding and retention of staff in this group. MA extended the Board's thanks to JLP for his interest in joining the trust, for his commitment and for relaying his personal experiences. He acknowledged that finding the right people was important and advised that the learning from JLP's experience was most welcome and that the People and Culture Committee would monitor the issues JLP had raised.	
BoD21/066	**Formalities**	
	The Chair declared the meeting open and quorate and welcomed members of public and governors to the meeting. Apologies for absence were received from Patricia Miller and Stuart Parsons.	
BoD21/067	**Declarations of Interest**	
	There were no conflicts of interest declared in the business to be transacted on the agenda with the following exception: NJ and ST were noted to also be Directors on the DCH Subco Board.	
BoD21/068	**Minutes of the Meeting held on the 29th September 2021**	
	Members of the Board considered the minutes of the meeting held on 29th September 2021**. Minor factual points from MA**	
	Resolved: that the minutes of the meeting held on 29th September 2021 were approved.	

BoD21/069	**Matters Arising: Action Log**	
	The action log was considered and the following updates were noted and approval was given for the removal of completed items.	
	Resolved: that updates to the action log be noted with approval given for the removal of completed items.	
BoD21/070	**CEO Update**	
	NJ presented key highlights from the report, drawing the board's attention to the following: • Many items within the report would be discussed in more detail on the agenda; • £5.9bn had been allocated to the NHS and further announcements around social care settlements were expected from the government; • Operational services remained under extreme pressure and the position was not expected to improve over the winter period; • COVID prevalence remained steady although emergency demand remained very challenging; • High bed occupancy rates persisted with high numbers of patients with no reason to reside; • Performance against quality metrics was being maintained; • Reducing waiting lists remained a challenge and a number of initiatives were in train to support this; • International recruitment expected to deliver a fully staffed nursing establishment by year end; • The trust had delivered the highest percentage of staff vaccinated against COVID-19 nationally; NJ noted later discussion of the Integrated Care System (ICS) and congratulated PM on her appointment as the ICS CEO. Congratulations were echoed by the board. NJ noted the recent 'Going the Extra Mile' Awards event recognising and celebrating staff achievements, innovation and good work. MA noted the excellent performance in some areas and less favourable performance in other areas and the action being taken to address these. The board recalled pre-pandemic discussion of multiyear financial agreements with trusts to support investment and acknowledged that this had not progressed due to the crisis. However, the trust would continue to lobby on this point. Current financing aimed to support the transition back to normal operations over the coming three years and further work to identify the resource requirements was underway. In response to a question on benchmarking the trust with other similarly sized organisations, the board were reminded that the Model Hospital contained peer group comparators which would be referenced in future reports where relevant.	

	It was clarified that the trust was working towards accreditation of the work it was undertaking as part of the Veterans Alliance and noted the recent establishment of the Veterans Staff Network. NJ undertook to feedback on which charities the trust was engaging with. MA commended South Walks House development which had been stood up in quick time and extended the board's thanks to the wide variety of teams involved in establishing the service and to the extensive volunteer workforce providing support.	NJ
	Resolved: that the CEO Update be received and noted.	
BoD21/071	**COVID-19 Update**	
	AT reported an increased number of patients admitted with COVID-19 and the number of patients with no reason to reside during October which had resulted in the need to change ward set ups in order to manage patient flow, ensure patient allocation to appropriate wards and safely manage ongoing care. There were currently 25 inpatients with COVID. The board noted the trust's initial preparations in response to the COVID Public Inquiry expected in spring 2022. Appointment of the Inquiry Chair was expected December. The Trust's initial response would be pragmatic and proportional until such time as the scope of the inquiry and terms of reference had been set. An internal Stop Notice had been issued across the trust in order to preserve records and arrangements to restore deleted records and the records of staff that had left the trust were noted. An inaugural meeting of an Inquiry Task Group had been scheduled in early December.	
	Resolved: that the COVID-19 Update be noted.	
BoD21/072	**Performance Scorecard and Board Sub-Committee March Escalation Reports**	
	The Non-Executive Chairs of the Board sub-committees provided feedback from committee meetings held the previous week and in October, noting the Escalation Reports and highlighting key points: **People and Culture Committee:** The board noted a better than average position for incident reporting. Bank and agency usage remained consistent although the need to maintain ongoing oversight of reductions was noted. Partners within the Dorset ICS were working together to reduce agency spend. A correction to the report was noted in that the percentage of staff that had undertaken the Staff Survey should be 43%. There had been an expected increase in the number of concerns raised via the Freedom To Speak Up (FTSU) Guardian following her recent appointment and the FTSU Plan had been approved.	

	Quality Committee: The mental health support offer for Emergency Department staff was being maintained. The ward accreditation process was being rolled out in support of the trust's ambition to provide outstanding care. Purbeck Ward had achieved the gold level award. The Healthy Living initiative on smoking cessation was noted. Risks relating to capacity and mixed sex accommodation use continued to be closely monitored and managed. The committee noted cross referencing with other committees and the continuing quality improvement work, particularly around pressure ulcer management and the support from Transformation team supporting further quality improvement initiatives. The Standardised Hospital Mortality Index (SHMI) had moved outside the expected range and had been reviewed in depth by the Quality Committee. Clinical coding appeared to be the cause and a detailed action plan was to be returned to a future meeting of the committee. The Mortuary Security Statement of Compliance had been approved. **Finance and Performance Committee:** The Board noted further Half Two planning discussion scheduled in part 2 of the meeting. The number of patients in hospital with no reason to reside represented 18-20% of the hospital bed base. The trust failed to achieve its financial performance target as a result of failure to gain income from the Elective Recovery Funding (ERF) initiative. The trust was expected to recoup the position in the second half of the year. Clinical Coding to support ERF funding had impacted the trust's SHMI. The committee noted the South Walks House initiative and the exceptional contribution of volunteers in providing additional patient throughput and expediting patient pathways. Feedback had been positive from both staff and patients. **Risk and Audit Committee:** A refreshed version of the Board Assurance Framework (BAF) had been presented, aligning risks with strategic objectives. This was supplemented by enhanced risk register reporting. The committee noted the cyber security update and the extensive and innovative nature of phishing attempts. The need to promote greater staff awareness of the need not to follow embedded links was emphasised. Digital Programme Board would in future report to the Finance and Performance Committee **System Performance Update** (Standing Item) NJ advised that the report demonstrated service pressures across the system and the need to reduce waiting lists and agency spend. The system wide financial position was also noted and provided context to the Board's discussion.	

	Resolved: that the Performance Scorecard, Board Sub-Committee Escalation Reports and System Performance Update be noted.	
BoD21/073	**Recovery Report** (Standing Item)	
	The Board was asked to note the report which triangulated the people and service recovery programme. The trust was performing well in achieving operational metrics relative to partners with the exception of waiting lists in the Oral Maxillo-facial service. Diagnostic services continued to perform well and were reducing waiting times and the numbers of patients waiting. The Board noted the innovative South Walks House initiative that supported the recovery programme (acquired learning from UHD) and the discussion with the council about a longer-term lease in order to extend the service. The pressures staff were under to meet day to day demands and deliver the recovery programme were reiterated and the board noted triangulation with the People and Culture Committee to ensure appropriate well-being support. The need to triangulate recruitment and retention and provide career pathway development and training opportunities for staff, in addition to the trust's international recruitment efforts, were emphasised and the role of the Education team in supporting opportunities for staff was acknowledged. Other innovative schemes such as the Kick Start and apprenticeship programmes provided further staffing opportunities and entry points to substantive employment. The Board noted the innovative ways staff continued to respond to the changing environment and ongoing engagement with other trusts to acquire learning from best practice. It was also highlighted that other trusts could take learning from DCH, for example regarding ambulance handovers.	
	Resolved: that the Recovery Report be noted.	
BoD21/074	**ICS Development Update** (Standing Item until March 2022)	
	NJ highlighted the following key points and reminded the board of planned discussion in December: • Integrated Care Board (ICB) – development of their Constitution and the transfer of CCG functions. • Development partnership criteria. • Integrated Care Partnership (ICP) proposals that had been co-designed with system partners. • The ICS Chair Designate would be the initial ICP Chair also. • The ICP would not have a hierarchical relationship to the ICB. • ICP would develop the Integrated Care Strategy and timescales. • All NHS organisations would be part of a Provider Collaborative from day one of the ICS. Regarding Place Based Partnerships, a first principles paper was included within the report which complimented the work currently and	

	aimed to align with the Local Authority and Health and Wellbeing Boards. Further discussion on this was planned in December. In response to a question seeking clarity on statutory commissioning responsibilities, the Board noted that CCG functions would transfer to the ICB and be further developed. NJ undertook to feed this into wider discussions.	NJ
	Resolved: that the ICD Development Update be Noted.	
BoD21/075	**DCH Strategy Implementation Biannual Update**	
	NJ presented the update which commenced biannual reporting on strategy implementation progress. Strategic outcome measures were being finalised and the Senior Leadership Group would support proposals and business cases going forward. The new Head of Strategy and Corporate Planning was expected to join the Trust in December and ensure linkages with digital developments and facilitate wider engagement activity. The Board noted realignment of the metrics was required following some refinement in the development of the BAF. Development of the Clinical Strategy was progressing with the involvement of other organisations in determining future pathways. AH clarified that the Clinical Strategy would be guided by the ICS and neighbouring partners and would therefore be reviewed on an annual basis. The Board noted the tripartite nature of the clinical, people and digital strategies and the interdependencies between them.	**NJ**
	Resolved: that the DCH Strategy Implementation Biannual Update be approved.	
BoD21/076	**Business Intelligence Update**	
	JW and HC joined the meeting for this item to outline the work of the Business Intelligence team and seek feedback from the board about their data requirements going forward. The Dorset Intelligence and Insight Service (DiiS) was developing the way data could be viewed and used by clinical teams to promote cross agency working, information sharing within the system and support decision making and strategic planning to the benefit of patient outcomes. The team continued to work with providers across sectors to promote reporting dashboards and present meaningful and useable data. A system-wide plan had been implemented recently to understand waiting list risks in order to identify targeted medical and social interventions. Analytics were used to describe and evidence deprivation and inequalities across the system and identify groups through a variety of data lenses in order that patients could be most appropriately treated. The Orthopaedic waiting list was cited by way of	

	example and analysis included consideration of co-morbidities, social deprivation and other risk factors such as increased demand on other services whilst patients remained on waiting lists. SA left the meeting. The board noted the growing capability and how data could be used to inform decision making, address inequalities in population health and support ICS founding principles. The board also recognised the potential to support targeted engagement in service developments and improving quality information going forward. The board considered data referencing and evidencing strategic decision making and the need to further champion the resource for clinicians, acknowledging the need to ensure appropriate resource to support clinical engagement. DiiS information would also help to inform development of the Clinical Strategy. MA thanked JW and HC for their presentation and summarised that the trust was delighted the DiiS were part of the DCH team offering systemwide services. It had been helpful to see how data was being used to support management of the waiting list. The need for focused thinking and links between strategies to address population health issues was noted. Success in addressing population health issues was reliant on clinical and operational service engagement. Expansion of the service would require appropriate resourcing. Members of the board were invited to contact the Business Intelligence team to discuss their future information requirements.	
	Resolved: that the Business Intelligence Update be received and noted.	
BoD21/077	**WDES Report**	
	DH presented key aspects of the report which provided an annual review of performance against metrics: Equality, Diversity and Inclusion (EDI) 18 month programme measured performance against 10 metrics and was published performance in October. The metrics showed consistency and a static picture. 3.5% of workforce had a disability and staff were being encouraged to update data in this regard. Next steps included further progression of the work plan, working with the Without Limits Staff Network which had improved staff experience and promoted workplace adjustments The Board noted that 30% of staff with a disability had experienced harassment at work and underlined the further work to address this in line with the Board's commitment to inclusive leadership. 26% of Board members had not declared their disability status and members were asked to update their declarations.	**All**

	Resolved: that the WDES Report be approved.	
BoD21/078	**Board Assurance Framework (BAF) and Risk Register**	
	NJ presented the new version of the BAF which reflected strategic risks to the achievement of the refreshed Trust Strategy and strategic Objectives. He invited further comment in terms of format and content in order that the document could add value to Board and committee discussion. Key strategic risks related to the workforce and finances. A sustainability risk had been added following discussion by the Risk and Audit Committee and work would continue to further develop the framework and review the operational nature of some risks. IM commented that the BAF dovetailed well with the Corporate Risk Register and that the new NED Designate had found it clear and understandable, welcoming the Heat map contained in the report. NL noted prior scrutiny of the Corporate Risk Register which aligned with discussion by the Board. She highlighted the emerging system-wide risk regarding the increasing number of patients occupying hospital beds with no reason to reside. The register would now be aligned with the BAF and to make milestones explicit. 'Deep dives' would continue to be undertake and reported to committees.	
	Resolved: that the Board Assurance Framework be received and noted.	
BoD21/079	**Social Value Action Plan Progress Update**	
	SPe attended for this item to update the Board on progress on implementation progress of the Social Value Plan which aimed to positively impact local communities from environmental and economic perspective, helping to address inequalities and promote health and well-being. SPe emphasised the commitment in the plan to embed social value across all programmes of work as these were being developed. A social value impact assessment had been developed in support of the strategy, business planning processes and policy. SPe advised that UHD, DHC and wider regional partners were taking learning from the trust's experience to support progression of the agenda more widely across the system. A Dorset Anchors Network was being established with the inaugural meeting expected in the near future and a Social Value Charter had been produced. The network would support a future bid to the Health Anchors Network to review procurement across Dorset in support of the social value ambition. The Board noted the pulling together of the various strategic strands to address population health and the opportunities for greater inclusion as the People Strategy developed. A further update would be presented to the Board in six months' time. SPe left the meeting	

	Resolved: that the Social Value Action Plan Progress Update be received and noted.	
BoD21/080	**Ambulance Handovers**	
	AT advised the Board of a recent letter from the Regional Office requiring action in 10 areas to improve ambulance handovers in support of reducing ambulance service delays. The trust was ranked top performing in the region with due regard being afforded to the privacy and dignity of patients where timely handovers could not be facilitate. The situation was a deteriorating and the trust had a task group in place to manage these delays and direct resources. The Emergency Department would have greater capacity on completion of the current development and refurbishment works. 'Corridor care' was being provided only in extremis and positive comments from the Ambulance service and CCG on the trust's approach to facilitate timely patient flow through the Emergency Department had been received. A 'queuing out' proposal outlined the trust's planned approach to handover management in extremis and the board was asked to approve this. A risk assessment of the proposal was in line with the trust's risk appetite statement and the proposal provided the safest option for managing in extremis in order to support ambulances to return to service. Whilst the trust would not ordinarily choose to undertake these actions, the proposal provided the safest options for supporting care and enabling ambulances to return to service. The Queuing Out proposal was approved.	
	Resolved: that the Ambulance Handovers briefing be received and noted. It was further resolved: that the Queuing Out proposal to support the Ambulance service in extremis be approved.	
BoD21/081	**National Patient Surveys**	
	EH joined for the item to present key messages and the views of people who use the trust surveys returned via several independent surveys undertaken by Picker. Surveys results had been pleasing overall and highlighted that A high percentage of patients had been appropriately communicated with and that opportunities for communication with relatives during visiting restrictions had been maintained. Patients reported that they had been treated with dignity and respect. The Trust ranked in the top five trusts in the region for respect and dignity and supporting visitors during the pandemic. Areas for further development included provision of further patient information related to surgery, noise at night and operation delays. The divisional services had developed clear development plans which would be monitored by the Patient Experience Group.	

	The board noted the culture of caring and support across the organisation that had delivered results at this level and this was a credit to staff. As pandemic restrictions eased slightly, there was increasing engagement opportunity for the Patient Experience team. The board recognised the use of social and local media to communicate these outcomes to the community and partners, the extensive engagement groups that informed discussion by the Patient Experience Group and the involvement of Healthwatch Dorset in the Patient Experience Group. The survey outcomes would support the trust's staff attraction campaign.	
	Resolved: that the National Patient Surveys be received and noted.	
BoD21/082	**Questions from the Public**	
	No questions were raised by the public.	
	CONSENT SECTION	
	The following items were taken without discussion. No questions were previously raised by Board members prior to the meeting.	
BoD21/083	**Maternity Safety Report**	
	Resolved: that the Maternity Safety Report be noted.	
BoD21/084	**DCH Subco Annual Report**	
	Resolved: that the DCH Subco Annual Report be approved.	
BoD21/085	**Complaints / Patient Experience Annual Report 2020/21**	
	Resolved: that the Complaints / Patient Experience Annual Report 2020/21 be noted.	
BoD21/086	**Mortuary Security Statement of Compliance**	
	Resolved: that the Mortuary Security Statement of Compliance be ratified.	
BoD21/087	**Any Other Business**	
	MA extended the thanks of the Board to IM for his tenure, chairing the Risk and Audit Committee and for his frank approach, bringing clarity and challenge to board discussion often with a sense of humour. The Board wished IM well for the future. IM stated that it had been a privilege working with the trust, particularly over the pandemic period and commended the good grace and dignity with which staff had operated.	

BoD21/088	Date and Time of Next Meeting
	The next Part One (public) Board of Directors' meeting of Dorset County Hospital NHS Foundation Trust will take place at **8.30am** on **Wednesday 26th January 2022.**

Action Log – Board of Directors Part 1

Presented on: 26th January 2022

Minute	Item	Action	Owner	Timescale	Outcome	Remove? Y/N
Meeting Dated: 24th November 2021						
BoD21/070	**CEO Update**	Provide feedback of which charities the trust is engaging with to support veterans	**NJ**	December 2021		
BoD21/074	**ICS Development Update**	Potential commissioning gaps and statutory commissioning responsibilities to be feed into ICB discussions to ensure this is on their agenda	**NJ**	December 2021		
BoD21/075	**DCH Strategy Implementation Biannual Update**	Strategy metrics to be realigned following refines made as the BAF was developed.	**NJ**	December 2021		
BoD21/077	**WDES Report**	Members of the Board to update disability status declarations	**All**	December 2021		
Meeting Dated: 29th September 2021						
BoD21/053	**Guardian of Safe Working Hours Report**	A discussion to be had with the Deanery to propose an extended work placement for medical students towards the end of their training to support transition form the education to work setting	**PM**	~~November 2021~~ January 2022		
Meeting Dated: 28th July 2021						
BoD21/027	**Matters Arising: Action Log**	Review of the revised report front sheets be added to the Board action log (from the NED action log) for consideration by the whole Board.	**TH**	~~November 2021~~ January 2022		
Actions from Committees…(Include Date)						

Meeting Title:	**Board of Directors' Meeting**
Date of Meeting:	**26th January 2022**
Document Title:	**Board and Committee Governance arrangements during the Omicron Crisis.**
Responsible Director:	**Mark Addison, Trust Chair**
Author:	**Trevor Hughes, Head of Corporate Governance**

Confidentiality:	Not confidential
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Board Development Session	15th December 2021	Approval of revised Board and Committee Governance arrangements in order to release Executive and operational Service Capacity.

Purpose of the Paper	This paper provides assurances to the Board that the actions agreed by the Board of Directors on 15th December 2021 in response to the government's requests to refocus the use of resources and release operational capacity to address the COVID Pandemic are consistent with NHS England and NHS Improvement's (NHSE/I) guidance issued on 24th December 2021. Following the emergence and rapid community transmission of the Omicron COVID-19 variant and in light of recent Prime Ministerial announcements and changes to national guidance, the NHS has been asked again to refocus operational priorities and resources and to release operational and Executive capacity in support of an accelerated vaccination programme rollout. This paper outlines the arrangements agreed by the Board on 15th December 2021 and provides assurances that these meet the requirements of the direction issued on 24th December 2021.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	The Board will recall that at the start of the pandemic in April 2020, the NHS was asked to reprioritise the use of available resources and release capacity to address the expected surge in COVID-19 cases. NHSE/I issued 'reducing the burden and releasing capacity' guidance in April 2020. This guidance stated: *Trusts and CCGs should continue to hold board meetings but streamline papers, focus agendas and hold meetings virtually not face-to-face. No sanctions for technical quorum breaches (e.g. because of self-isolation)* *For board committee meetings, trusts should continue quality committees, but consider streamlining other committees (e.g. Audit and Risk and Remuneration committees) and where possible delay meetings till later in the year.* The emergence and rapid spread of the Omicron COVID variant within the community has resulted in several recent changes in national guidance. The increased community prevalence of Omicron prompted the four national Medical Directors to raise the COVID threat level to 4 on 12th December 2021. NHS England / Improvement (NHSE/I) also raised the National Incident level to 4.							

The impact of the Omicron variant is becoming clearer over time with:

- Significantly increased number of cases within the community leading to an increase in the number of people requiring hospitalisation,
- Increasing staff absence across all sectors impacting the continued ability of the NHS to continue to provide safe services. At the time of writing, 20 NHS Trusts had declared critical incidents,
- Increasing urgent care demands on services including Ambulance and Accident and emergency services'
- Increased numbers of medically fit people that cannot be discharged due to social care staffing shortages and the availability of suitable social care support.

Consequently, national guidance changed to include the wearing of masks in public places and reintroduced the requirement for staff to work from home where this was possible. On the 12th December 2021, the Prime Minister announced a significant increase in the vaccination rollout programme to ensure that the population was optimally protected from serious illness and hospitalisation; protecting the NHS from being overwhelmed over the winter period. He asked the NHS and care partners to focus on the rollout out programme as a priority and to facilitate the creation of acute and community capacity, releasing resources from non urgent activity to support the mass vaccination programme and support safe discharge of patients. A subsequent letter dated 12th December 2021 from NHSE/I makes the operational imperative to maximise acute and community capacity, enable safe discharge and support of people in their own homes clear.

In response to this surge in cases and the changing profile of the pandemic resulting in increasing operational service pressure, the Board discussed what action it could take to release executive and support service operational capacity at their Board Development session on 15th December 2021 and agreed the following actions:

1. Staff to be supported to work from home where this was possible.
2. All Board and committee meetings to continue to be conducted remotely using video conferencing facilities.
3. Members of the public and Governors to continue to be provided access to public meetings of the Board via videoconferencing links.
4. Divisional and service representation and attendance at Board and committee meetings to be suspended temporarily.
5. Previous temporary amendments to committee terms of reference (from April 2020) to reduce Executive attendance in order to release capacity.to be re-implemented.
6. No formal changes to Board and committee Agendas although Chairs and Executives would keep meetings as short as possible focussing on key risks and priorities.
7. Some scheduled work programme items to be deferred and recorded within respective committee Action Logs for later consideration.
8. NED attendance at the hospital and Patient Safety Visits to be temporarily suspended.
9. The schedule of Board meetings would remain unchanged.

On 24th December 2021, NHSE/I issued a national letter to NHS and partner organisations updating their position on regulatory and reporting requirements for NHS organisations in light of these pressures in order to support the release of capacity to address the national pandemic priorities, deliver the vaccination booster programme, support discharges from hospital and focus on urgent and emergency care and elective recovery priorities.

	The letter advises organisations to streamline oversight meetings, assurance and reporting requirements and take measures to support recovery and safety. The actions taken by the Trust following the Board Development session on 15th December 2021 are consistent with the letter issued by NHSE/I on 24th December 2021 and previously issued national guidance in April 2020. The NHSE/I letter also outlines adjustments to and easing of some reporting requirements, where these are possible. NHSE/I will remain focussed on those standards most directly impacted by the pandemic including: • A&E and Ambulance Performance • Referral to Treatment times • Discharge • Cancer referrals, treatment and screening • Immunisations The Board is asked to note amendments to the performance reporting standard requirements and NHSE/I's approach to tracking key indicators.
Action recommended	The Board of Directors is asked to note that actions taken following the Board Development session on 15th December 2021 meet with the requirements of the NHSE/I letter of the 24th December 2021 and to note changes to the performance reporting arrangements.

Governance and Compliance Obligations

Legal / Regulatory	Y	The Board of Directors seeks to continue to operate in an open and transparent manner maintaining accountability to the trust's Governors, members and the wider public in accordance with the requirements placed on organisations operating in the public domain and with foundation trust license conditions.
Financial	N	
Impacts Strategic Objectives?	N	
Risk?	Y	The temporary actions taken by the Trust enables executive and operational service capacity to be released and enables the Board of Directors and committees to remain sighted on key risks and activities.
Decision to be made?	N	
Impacts CQC Standards?	Y	It is important that the Board of Directors and committees remain sighted on key risks and issues and that the Trust remains well led during the period of temporary amendments to Board and committee Governance arrangements.
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

To:
- Chief executives of all NHS trusts and foundation trusts
- CCG accountable officers
- GP practices and PCNs
- Providers of community health services
- NHS 111 providers
- PCN-led local vaccination sites
- Vaccinations centres
- Community pharmacy vaccination sites
- ICS and STP leads

cc.
- NHS regional directors
- NHS regional directors of commissioning
- Regional incident directors
- Regional heads of EPRR
- Chairs of ICSs and STPs
- Chairs of NHS trusts, foundation trusts and CCG governing bodies
- Local authority chief executives and directors of public health

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

24 December 2021

Dear Colleague

Reducing the burden of reporting and releasing capacity to manage the COVID-19 pandemic

Once again, the NHS is facing a significant challenge from COVID-19. As we continue to manage infections from the Delta variant, the Omicron variant is growing substantially and once again there is a risk of significant levels of COVID-19 hospitalisations with the challenges these place across the whole NHS. At the same time, the NHS is delivering a national COVID booster vaccination programme and continuing to provide essential non-COVID care.

This letter should be read in conjunction with 'Preparing the NHS for the potential impact of the Omicron variant and other winter pressures', which declared a Level 4 National Incident.

Following our letters in March and July last year and January, this letter updates our position on regulatory and reporting requirements for NHS trusts and foundation trusts, including:

- streamlining oversight meetings
- streamlining assurance and reporting requirements
- providing greater flexibility on various year-end submissions
- focusing our improvement resources on COVID-19, vaccination, discharge, UEC and elective recovery priorities
- only maintaining development workstreams that support recovery and safety.

Our intention is that the measures here will collectively help you free up resource to address the priorities we have set out.

We will keep this under close review, making further changes where necessary to support you and remaining mindful of the balance between timely information and not flooding the service with requests. We will review and update the measures set out in this letter in Q1 2022/23.

Once again, we appreciate the incredible level of commitment and hard work from you and your teams that has helped the NHS rise to meet the challenge of COVID-19 since March 2020.

Sir David Sloman
Chief Operating Officer
NHS England and NHS Improvement

A) Governance and meetings

No.	Areas of activity	Detail	Actions
1.	Board and sub-board meetings	Trusts and CCGs should continue to hold board meetings but streamline papers and focus agendas. No sanctions for technical quorum breaches (eg because of self-isolation). For board committee meetings, trusts should continue quality committees, but consider streamlining other committees. While under normal circumstances the public can attend at least part of provider board meetings, government social isolation requirements constitute 'special reasons' to avoid face-to-face gatherings as permitted by legislation. All system meetings to be virtual unless there is a specific business reason to meet face to face.	Organisations to inform audit firms where necessary
2.	FT governor meetings	Face-to-face meetings should be stopped wherever possible at the current time[1] – virtual meetings can be held for essential matters e.g. transaction decisions. FTs must ensure that governors are (i) informed of the reasons for stopping meetings and (ii) included in regular communications on response to COVID-19, eg via webinars/emails.	FTs to inform lead governor
3.	FT governor and membership processes	FTs free to stop/delay governor elections where necessary. Annual members' meetings should be deferred. Membership engagement should be limited to COVID-19 purposes.	FTs to inform lead governor
4.	Annual accounts and audit	Wherever possible the NHS England and NHS Improvement accounts team will reduce the administrative burden of year-end accounts as far as is possible, but the current intention is to stick with the published timetable. We will, as ever, remain responsive to challenges as they emerge.	Organisations to continue with year-end planning in light of updated guidance
5.	Quality accounts – preparation	The deadline for quality accounts preparation of 30 June is specified in Regulations. As in previous years, we intend to write to all providers concerning the requirements for 2021/22 Quality Accounts.	No action for organisations at the current time

[1] This may be a technical breach of foundation trusts' constitution but acceptable given government guidance on social isolation.

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8.	Decision-making processes	While having regard to their constitutions and agreed internal processes, organisations need to be capable of timely and effective decision-making. This will include using specific emergency decision-making arrangements.	

B) Reporting and assurance

No.	Areas of activity	Detail
1.	Constitutional standards (eg A&E, RTT, cancer, ambulance waits, mental health and learning disability measures)	See Annex A
2.	Friends and Family Test	Reporting requirement to NHS England and NHS Improvement has been resumed. Note that trusts have flexibility to change their arrangements under the new guidance, and published case studies show how trusts can continue to hear from patients while adapting to pressures and needs. We emphasise local discretion.
3.	Long Term Plan: mental health	NHS England and NHS Improvement will maintain the Mental Health Investment Guarantee. As a foundation of our COVID-19 response, systems should continue to expand services in line with the LTP.
4.	Long Term Plan: learning disability and autism	Systems should continue learning disability and autism investment and transformation to support the LTP.
5.	Long Term Plan: cancer	NHS England and NHS improvement will maintain their commitment and investment through the Cancer Alliances and regions to improve survival rates for cancer. We will work with Cancer Alliances to prioritise delivery of commitments that free up capacity and slow or stop those that do not, in a way that will release necessary resource to support the COVID-19 response

No.	Areas of activity	Detail
		and restoration and maintenance of cancer screening programmes (including bowel and targeted lung checks) and symptomatic pathways.
6.	Long Term Plan: maternity and neonatal	Systems should ensure that maternity services can operate safely in the pandemic context and continue to implement initiatives which support this, such as Saving Babies' Lives and the seven Immediate and Essential Actions from the Ockenden report. We will work with local maternity systems to prioritise delivery of commitments that free up capacity and slow or stop those that do not, in a way that will help them to maintain safe services. This will include reviewing planning milestones, such as submission of plans to roll out continuity of carer and improve equity.
7.	GIRFT and transformation programmes	Routine GIRFT visits to trusts have been stood down with resources concentrated on supporting hospital discharge co-ordination and HVLC work. National transformation programmes (outpatients, diagnostics and pathways) now focus on activity that directly supports the COVID response or recovery, eg video consultation, personalised outpatients and patient-initiated follow-up, maximising diagnostics and clinical service capacity, supporting discharge priorities, etc.
8.	NHS England and NHS Improvement oversight meetings	Oversight meetings will continue to be held by phone or video conference unless it is agreed that there is a compelling business reason to hold them face-to-face, and they will focus on critical issues. Teams will also review the frequency of these meetings on a case-by-case basis to ensure it is appropriate, streamlining agendas to focus on COVID-19 issues/discharge/recovery/ winter and support needs.
9.	ICS development activity	System working is essential in managing the response to COVID-19 and delivering the NHS's priorities in 2022/23. Work to establish ICSs – and ICBs as statutory NHS bodies – continues, with a revised target date of July 2022. This will allow sufficient time for the remaining parliamentary stages of the Health and Care Bill and provide some extra flexibility for systems in preparing for the new statutory arrangements and managing the immediate priorities in the pandemic response.
10.	Corporate data collections (eg licence self-certs, annual governance statement, mandatory NHS Digital submissions)	Look to streamline and/or waive certain elements. Delay the forward plan documents FTs are required to submit. We will work with analytical teams and NHS Digital to suspend agreed non-essential data collections.

No.	Areas of activity	Detail
11.	CQC routine assessments, Use of Resources assessments, HSIB investigations	With CQC, we continue to prioritise our Recovery Support Programme work to give the appropriate support to the most challenged systems to help them manage COVID-19 pressures. CQC has suspended routine assessments and currently uses a risk-based transitional monitoring approach. NHS England and NHS improvement continue to suspend the Use of Resources assessments in line with this approach. Visits and inspections in connection with HSIB investigations will also be reduced.
12.	Provider transaction appraisals – mergers and subsidiaries	Potential for NHS England and NHS Improvement to deprioritise or delay transactions assurance if in the local interest given COVID-19 factors.
	Service reconfigurations	Urgent temporary service changes on safety grounds in response to COVID-19 or other pressures can still be made with agreement from system partners. Should systems look to make these permanent, normal reconfiguration assurance processes will apply at a later stage.
13.	7-day services assurance	No changes – self-cert statements to continue.
14.	Clinical audit	Given the importance of clinical audit in COVID and non-COVID care, clinical audit platforms will remain open for data collection. It should be noted clinical teams should always prioritise clinical care over data collection and submission.
15.	Pathology services	We need support from providers to manage pathology supplies which are crucial to COVID-19 testing. Trusts should not penalise those suppliers who are flexing their capacity to allow the NHS to focus on COVID-19 testing equipment, reagent, and consumables. Trusts must also continue to support the prioritisation of covid testing and genotyping services within their own laboratories.

C) Other areas including primary care, HR and staff-related activities

No.	Areas of activity	Detail
1.	Mandatory training	With staff absences likely to rise, new training activities – eg refresher training for staff and new training to expand the number of ICU staff – are likely to continue to be necessary. Reduce other mandatory training as appropriate.
2.	Appraisals and revalidation	Professional standards activities may need to be reprioritised: eg appraisals can be postponed or cancelled. Appraisal is a support for many doctors, so it is helpful to keep the option available, but if going ahead, please use the shortened Appraisal 2020 model. Medical directors may also use discretion to decide which concerns require urgent action and which can be deferred.

		The Nursing and Midwifery Council (NMC) has also extended the revalidation period for current registered nurses and midwives by an additional three months for those due to revalidate between December 2021 and March 2022.
3.	Primary care	We have already announced a series of changes to GP contract arrangements and some changes for community pharmacy.
4.	CCG clinical staff deployment	Review internal needs to retain a skeleton staff for critical needs and redeploy the remainder to the frontline. CCG governing body GPs to focus on primary care provision and booster campaign.
5.	Repurposing non-clinical staff from CCGs	Non-clinical staff to focus on supporting primary care and providers to maintain and restore services and the vaccine booster programme.
6.	Enact business critical roles at CCGs	To include support and hospital discharge, EPRR etc.

Annex A – constitutional standards and reporting requirements

While existing performance standards remain in place, we continue to acknowledge and appreciate the challenges in maintaining them during the continuing COVID-19 response. Our approach to tracking those standards most directly impacted by the COVID-19 situation is set out below.

A&E and ambulance performance – Monitoring and management against the four-hour standard and ambulance performance continues nationally and locally, to support system resilience.

RTT – Monitoring and management of RTT and waiting lists will continue, to ensure consistency and continuity of reporting and to understand the impact of the suspension of non-urgent elective activity and the subsequent recovery of the waiting list position that will be required. Application of financial sanctions for breaches of 52+ week waiting patients occurring during 2020/21 continue to be suspended. Recording of clock starts and stops should continue in line with current practice for people who are self-isolating, people in vulnerable groups, patients who cancel or do not attend due to fears around entering a hospital setting, and patients who have their appointments cancelled by the hospital.

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(This has already been communicated to data submission leads via NHS Digital.)

Meeting Title:	Board of Directors
Date of Meeting:	26 January 2022
Document Title:	**Chief Executive's Report**
Responsible Director:	Nick Johnson, Interim CEO
Author:	Natalie Violet, Corporate Business Manager to the CEO

Confidentiality:	The document is not confidential
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Interim Chief Executive	18/01/2022	Approved

Purpose of the Paper	For information.							
	Note	✓	*Discuss*		*Recommend*		*Approve*	
Summary of Key Issues	This report provides the Board with further information on strategic developments across the NHS and more locally within Dorset. It also includes reflections on how the Trust is performing and the key areas of focus. The key developments nationally are as follows: • The Secretary of State for Health and Social Care commissioned a review into possible racial and gender bias in medical devices • The Chief Nursing Officer for England published their strategy plan for research • Major reforms were announced putting recruitment, training, and retention of NHS staff and digital transformation at the heart of NHS England • The NHS Race and Health Observatory published their strategy outlining their priorities • NHS England published the future of NHS human resources and organisational development report which outlines the ten-year strategy for the human resources and organisational development services in the NHS • At the end of November, cases of the new Omicron COVID variant were confirmed in the UK. Due to the new variant and advice from SAGE, UK Chief Medical Officers increased the COVID threat to level 4. As a result of this NHS England and Improvement declared a Level 4 National Incident in recognition of the impact of delivering additional vaccinations and preparing for a potential surge of hospitalisations. • NHS England and Improvement published the 2022/23 priorities and operational planning guidance acknowledging the immediate operational focus of delivering the objectives outlined to tackle the Omicron variant. The planning timetable and submission deadlines were therefore extended to the end of April 2022 with draft plans in mid-March. The guidance outlines ten priorities for systems which are based on COVID activity and disruption returning to early summer 2021 levels • Following the publication of the planning guidance it was confirmed the move to put Integrated Care Systems on a statutory footing has been delayed from 01 April 2022 and will now occur on 01 July 2022 Locally the biggest concerns remain with emergency demand, delayed discharges, and staffing. We continue to work with our community and local authority colleagues to reduce delayed discharges and free up beds. Staffing challenges have been exacerbated due to the Omicron variant and our daily							

	staffing meetings are in place to ensure staff levels in clinical areas are as safe as possible. We continue with our international recruitment with the aim to be fully staffed in terms of nursing establishments by March 2022. Despite these challenges our teams are responding exceptionally well.
Action recommended	The Board of Directors is recommended to: 1. **NOTE** the information provided.

Governance and Compliance Obligations

Legal / Regulatory	Y	Failure to understand the wider strategic and political context, could lead to the Board to make decisions that fail to create a sustainable organisation.
Financial	Y	Failure to address key strategic and operational risks will place the Trust at risk in terms of its financial sustainability.
Impacts Strategic Objectives?	Y	For the Board to operate successfully, it must understand the wider strategic and political context.
Risk?	Y	Failure to understand the wider strategic and political context, could lead to the Board making decisions that fail to create a sustainable organisation. The Board also needs to seek assurance that credible plans are developed to ensure any significant operational risks are addressed.
Decision to be made?	N	No decision required; this report is for information.
Impacts CQC Standards?	Y	An understanding of the strategic context is a key feature in strategy development and the Well Led domain. Failure to address significant operational risks could lead to staff and patient safety concerns, placing the Trust under increased scrutiny from the regulators.
Impacts Social Value ambitions?	N	No impact on social value ambitions
Equality Impact Assessment?	N	EIA not required; this report is for information
Quality Impact Assessment?	N	QIA not required; this report is for information

Chief Executives Report – January 2022

Strategic Update

National Perspective

Racial Bias in Medical Devices
In November, the Secretary of State for Health and Social Care, Sajid Javid commissioned a review into possible racial and gender bias in medical devices, using research suggesting pulse oximeters overstating the level of oxygen in the blood of people from ethnic minorities as an example. Ministers would like to understand if bias could have prevented patients receiving appropriate COVID treatment. An independent chairman is yet to be appointed however the initial findings are expected in early 2022.

Chief Nursing Officer for England's Strategy Plan for Research
On 19 November 2021, the Chief Nursing Officer published Making research matter Chief Nursing Officer for England's strategic plan for research. The plan sets out a policy framework for developing and investing in research activity across the NHS in partnership with others. There is a shared ambition to create a people-centred research environment empowering nurses to lead, participate in, and deliver research, embedding research in practice and professional decision-making to benefit the public.

Major Reforms to NHS Workforce Planning and Tech Agenda
On 22 November 2021, the Secretary of State for Health and Social Care, Sajid Javid, announced new reforms which will put recruitment, training, and retention of NHS staff and digital transformation at the heart of NHS England. The plans aim to benefit patients by providing the best possible care with the right staff in place to meet their needs. This supports the strategic NHS workforce framework previously commissioned, expected in the Spring, looking at what the workforce of the future should look like.

The intention is to merge Health Education England with NHS England and Improvement putting long-term planning and strategy for healthcare staff recruitment and retention at the forefront of the national NHS agenda. The Secretary of State also accepted the recommendation to merge NHSX and NHS Digital into NHS England and Improvement.

NHS Race and Health Observatory Strategy
On 29 November 2021, the NHS Race and Health Observatory published their strategy – Driving Race Equity in Health and Care for 2021 – 2024. The strategy outlines the Observatory's priorities across five core workstreams; improving health and care, empowering vulnerable communities, innovating for all, creating equitable environments, and collaborating globally.

Local Relevance

The Future of Human Resources and Organisational Development
On 22 November 2021 NHS England published the future of NHS human resources and organisational development report which outlines the ten-year strategy for the human resources and organisational development services in the NHS. The report includes a vision and actions that support the delivery of the four pillars of the NHS People Plan and embeds the seven elements of the People Promise. Locally this will be linked to our new people strategy, the development of the Integrated Care System (ICS) people strategy and provides an opportunity to develop people teams across the system. The report further strengthens the direction of travel for ICS wide digital solutions to improve the efficiency and effectiveness of people processes and functions.

Omicron Variant
At the end of November, cases of the new Omicron COVID variant were confirmed in the UK. On 12 December 2021, the Prime Minister announced the national response to tackle Omicron by increasing vaccinations. Early evidence indicated people who have had two primary vaccinations plus their booster are likely to be protected from serious illness but can still be infected and be part of the train of transmission.

Due to the new variant and advice from SAGE, UK Chief Medical Officers increased the COVID threat to level 4. As a result of this NHS England and Improvement declared a Level 4 National Incident, on 13 December 2021, in recognition of the impact of delivering additional vaccinations and preparing for a potential surge of COVID hospitalisations. Systems were therefore asked to:

- Ensure the successful ramp-up of the COVID vaccination programme
- Maximise the availability of COVID treatments for patients at highest risk of severe disease and hospitalisation
- Maximise capacity across acute and community settings, enabling the maximum number of people to be discharged safely and quickly and support people in their own homes
- Support patient safety in urgent care pathways across all services, and manage elective care
- Support staff, and maximise their availability
- Ensure surge plans and processes are ready to be implemented if needed

NHS England and Improvement were asked by the Government to maximise the use of independent sector bed capacity should local NHS bed capacity be significantly overwhelmed due to the Omicron variant. Following a letter from Amanda Pritchard, NHS Chief Executive highlighting the associated risks and costs the Secretary of State of Health and Social Care, Sajid Javid, asked for the scheme to be taken forward acknowledging the need to protect NHS services in light of Omicron.

Chief Executives across the South West have been meeting regularly to plan for a potential surge of Omicron. Major incident plans and procedures are in place and will be enacted should admission numbers reach predicted levels. If necessary. a field hospital will be opened in Bristol. It is important to recognise the South West have the highest vaccination rate in England therefore are in a good position going into a potential surge.

Locally, we have been working with our community and local authority colleagues to significantly increase discharges to free up beds. If we manage to achieve this, it will make the handling of any potential surge much easier. Our Incident Management Team continue to meet daily, and sometimes, if required, twice a day to monitor the situation. The main challenges are high bed occupancy due to non-COVID demand, delayed discharges, staff absences, and issues with patient flow. We have experienced several patients being confirmed as COVID positive on routine swabbing despite not being initially admitted for COVID. Consequently, bays have been closed for infection prevention which has impacted flow. Staffing remains challenged with high absence numbers due to testing positive or the need to isolate. Our Workforce Cell is now meeting daily to provide oversight and ensure staff levels in clinical areas are as safe as possible.

NHS 2022/23 Priorities and Operational Planning Guidance

On 24 December 2021, NHS England and Improvement published the 2022/23 priorities and operational planning guidance. It acknowledges the immediate operational focus would be delivering the objectives outlined to tackle the Omicron variant. The planning timetable and submission deadlines were therefore extended to the end of April 2022 with draft plans in mid-March. The guidance outlines ten priorities for systems which are based on COVID activity and disruption returning to early summer 2021 levels. The ten priorities are:

1. Investing in the workforce and strengthening a compassionate and inclusive culture
2. Delivering the NHS COVID-19 vaccination programme
3. Tackling the elective backlog
4. Improving the responsiveness of urgent and emergency care and community care
5. Improving timely access to primary care
6. Improving mental health services and services for people with a learning disability and/or autistic people
7. Developing approach to population health management, prevent ill-health, and address health inequalities
8. Exploiting the potential of digital technologies
9. Moving back to and beyond pre-pandemic levels of productivity
10. Establishing Integrated Care Boards and enabling collaborative system working

Delay to Integrated Care System Reform
Following the publication of the planning guidance it was confirmed the move to put Integrated Care Systems on a statutory footing has been delayed from 01 April 2022 and will now occur on 01 July 2022. Locally the Dorset Integrated Care Board governance framework has been agreed and the Executive Director consultation ended in early January with the matching process expected to conclude in February. Two Non-Executive Directors have been appointed and the search to appoint a further four is underway. Working on the assumption the Board will be in place by 01 April 2022 the intention is to run in shadow form until 30 June 2022 which will offer the opportunity to test the governance structure.

NHS England Non-Executive Director Visit
On 02 December 2021, the Dorset System welcomed some of the Non-Executive Directors from NHS England to look at a few of our achievements across the health and care system. It was a very engaging event providing an opportunity to receive feedback on where they think we could improve and stretch ourselves.

University Hospitals Dorset – Chief Executive Appointment
Following successful interview in December, Siobhan Harrington was appointed as substantive Chief Executive at University Hospitals Dorset. Siobhan is an experienced director in the NHS and has been Chief Executive of Whittington Health NHS Trust in London since 2017. She will be taking up the role from 01 June 2022. Siobhan will be succeeding Debbie Fleming who will be retiring on 31 March 2022. Paula Shobbrook will be acting as Interim Chief Executive during April and May.

DCH Performance

Wessex Trauma Network Peer Review
On 18 November 2021, the Wessex Trauma Network undertook an annual peer review of our Trauma Unit's performance. We were commended for the huge amount of progress made since the previous year's review with no immediate risks or serious concerns identified. The review identified the need to recognise any gaps in education provision for staff caring for trauma patients across the organisation and the need to bolster the existing Trauma Coordinator Service to provide an overarching service across the hospital.

Healthcare Financial Management Association Awards
The Healthcare Financial Management Association annual awards were held on 09 December 2021. Our Dorset Intelligence and Insight Service (DiiS) team won the award for Delivering Value with Digital Technologies. This is a fantastic achievement and recognises the hard work and dedication of the entire business intelligence team. They have developed some excellent tools to manage performance and service delivery for both clinicians and managers.

Children and Young People Experience Survey
In December we received the results of the Children and Young People Patient Experience Survey which is carried out by the Picker Institute of behalf of the Care Quality Commission. The survey captured the views of 105 children and young people and their parents, aged 15 days to 15 years old when discharged between the 01 November 2020 and 31 January 2021. It revealed that 95% of children and 96% of patients felt well looked after by staff.

We were rated above average in providing parents with written information about their child's condition or treatment; having enough for their child to do; access to hot drinks facilities and being told what to do or who to contact if they were worried once home. Children also ranked the hospital food highly. Parents rated the overnight facilities highly, felt there was strong wi-fi for their child to be entertained and that staff were aware of their child's medical history and explained how their child's operation or procedure had gone. Parents also praised the level of engagement staff had with their child.

Chemotherapy Appeal Target
In December our DCH Charity announced the Chemotherapy Appeal Target was successfully reached. The Appeal target of £850,000 has been achieved thanks to the generosity of hundreds of donors and fundraisers and some significant donations. Working in partnership with the Fortuneswell Cancer Trust,

the Appeal is funding the complete redesign and refurbishment of the Fortuneswell Chemotherapy Unit. The new unit will provide an improved environment for the treatment of chemotherapy patients including the provision of space for friends and family to sit with patients receiving treatment.

Nick Johnson
Interim Chief Executive
18 January 2022

Meeting Title:	Board of Directors
Date of Meeting:	26 January 2022
Document Title:	**Recovery Overview**
Responsible Director:	Nick Johnson, Interim Chief Executive
Author:	Natalie Violet, Corporate Business Manager to the Chief Executive

Confidentiality:	Not confidential
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Chief People Officer, Interim Chief Operating Officer, and Interim Chief Executive	21/01/2022	Approved

Purpose of the Paper	The purpose of the report is to provide the Trust Board with an overview of progress against the Trust's Recovery Framework following the COVID-19 pandemic.							
	Note	✓	*Discuss*		*Recommend*		*Approve*	

Summary of Key Issues	Highlights include:
	• The People Recovery Steering Group continues to meet on a bi-monthly basis.
	• November and January meetings focused on:
	  ○ The need to provide supervision support to the Mental Health First Aiders, particularly as they are undertaking regular wellbeing walkabouts.
	  ○ The benefits of extending coaching opportunities to all Divisional Management Team and Senior Leadership Group members
	  ○ The need to provide a clearer description of the support and resources provided by the Organisational Development Team via a re-launch of the service
	  ○ Exploring whether the Dignity and Respect at work module for bands 1 – 6 can be offered to all staff.
	  ○ The future of the onsite counselling service as funding for the existing service is only confirmed until the end of March 2022. The group is looking to ensure a request to extend the funding is included in the 2022/23 business planning process.
	  ○ Sharing some data relating to the current onsite counselling service and potential ideas for developing the service for the benefit of our staff.
	  ○ A demonstration of the new wellbeing intranet site devised by the Organisational Development Team which is due to be launched in early 2022 and includes a self-assessment element to help staff access the right support at the right time.
	• Performance on clock stop activity against the Elective Recovery Fund continues to overachieve against the target of 89%.
	• This month we can report on patients with a learning disability as we are now able to identify patients on our waiting lists with a learning disability flag.
	• BI Teams across the system are working on automated reporting for deprivation waiting times.
	• In December the total waiting list size decreased by 778 patients compared to the previous month. This takes the total waiting list size to							

	4,446 below trajectory. • At the end of December, there were 1,703 patients waiting over 52 weeks for treatment. This is an increase of 24 patients compared to the previous month and is 297 fewer than trajectory. • As part of the second half of 2021/22 planning submission, a 104+ week wait trajectory was required. At the end of December, there were 216 patients waiting over 104+ weeks, this is 1 patient more than trajectory. Our submission highlights our inability to reach zero 104+ week waiters by the end of March 2022. • The organisation's waiting list profile ranking in the Region is not ideal however, the significant reduction in 52+ week waiters beyond trajectory is pleasing. • Our multi professional clinics from South Walks House continue and are integral to ongoing elective recovery and mitigating further elective growth. • We are currently looking at the opportunity to secure South Walks House on a long-term basis to enable further service recovery whilst also addressing and unlocking other strategic infrastructure requirements.
Action recommended	The Trust Board is recommended to: 1. **Note** the information provided.

Governance and Compliance Obligations

Legal / Regulatory	Y	Failure to monitor progress against the Trust's Recovery Framework could result in further deterioration of standards. Ensuring the Trust Board has oversight of the recovery ensures they are sighted on those areas that are outside of our control and those which require focus.
Financial	Y	Failure to monitor progress against the Trust's Recovery Framework could result in further deterioration of standards. Ensuring the Trust Board has oversight of the recovery ensures they are sighted on those areas that are outside of our control and those which require focus.
Impacts Strategic Objectives?	Y	Delivery of outstanding care. Significant impact on patient and staff experience and reputation of poor performance with commissioners, regulators, and the public.
Risk?	Y	The clinical impact of COVID-19 on planned care and patients that are not clinically urgent is not understood yet, but a clinical risk stratification programme is in development, which follows the nationally published guidelines. Harm cannot be determined until the patient is seen.
Decision to be made?	N	No decision required.
Impacts CQC Standards?	Y	Ensuring robust oversight against the Trust's Recovery Framework links with the CQC well-led domain.
Impacts Social Value ambitions?	N	The recovery approach supports the organisations Social Value ambitions by being a supportive employer and recovering elective services for our local communities, embedding equity in health outcomes into restart processes.
Equality Impact Assessment?	N	The Elective Performance Management Group (EPMG) are focusing on addressing waiting list health inequalities, with a particular focus on ethnicity and deprivation.
Quality Impact Assessment?	N	Quality Committee are providing oversight of patient outcomes.

Title of Meeting	Board of Directors
Date of Meeting	26 January 2022
Report Title	**Recovery Overview**
Author	Natalie Violet, Corporate Business Manager to the Chief Executive
Responsible Executive	Nick Johnson, Interim Chief Executive

1.0 Introduction

The Board of Directors approved the Trust's Recovery Framework on 28 July 2021. This report provides an overview of progress against the framework.

2.0 Recovery Framework

The organisations recovery priority is twofold – our NHS people and clinical services. The approach is in line with the national 2021/22 Priorities and Operational Planning Guidance, published on 25 March 2021. With objectives for both people and service recovery aligned to this guidance.

Reporting to Board sub-committees is now in place including recovery metrics and performance against trajectories.

3.0 People Recovery

The People Recovery Steering Group
The People Recovery Steering Group is meeting on a bi-monthly basis. The focus of the group is broader than traditional health and wellbeing steering groups. It attends to the foundations of wellbeing – supply, retention, experience, in addition to directing individual and team wellbeing support. The agreed duties and responsibility of the group are as follows:

- Act as a channel through which policies, procedures, and organisational issues relating to people recovery will be discussed. This will include feedback from the regular wellbeing walkabouts and emerging themes from the counselling, Employee Assistance Programme and Occupational Health services.
- To provide communication with, and feedback to, Divisions regarding people recovery initiatives and programmes being supported, implemented, or considered.
- To review annual and quarterly staff survey data and develop appropriate Trust level action plans to raise satisfaction levels in relation to health and wellbeing.
- To review its own performance, constitution, and terms of reference on an annual basis to ensure it is operating at maximum effectiveness.

Operational matters which cannot be satisfactorily resolved at local department level or through the appropriate channels and procedures can be referred to the People Recovery Steering Group if necessary.

Meetings took place in November and January. Items discussed during the November meeting included:

- The need to provide additional supervision and support to the Mental Health First Aiders, particularly as they are undertaking regular wellbeing walkabouts.
- The benefits of extending coaching opportunities to all Divisional Management Team and Senior Leadership Group members
- The need to provide a clearer description of the support and resources provided by the Organisational Development Team via a re-launch of the service
- The success of the Dignity and Respect at work training for bands 1 – 6 and whether it could be extended to all staff

January's meeting focused on the future of the onsite counselling service as funding for the existing service is only confirmed until the end of March 2022. The group is looking to ensure a request to extend the funding is included in the 2022/23 business planning process. The group invited Ian Smith, who is a Wellbeing and Mental Health Counsellor with Wellbeing Practice who currently provide our on-site counselling service, to share some data relating to the current service and potential ideas for developing the service for the benefit of our staff.

The group also received a demonstration of the new wellbeing intranet site devised by the Organisational Development Team which is due to be launched in early 2022 and includes a self-assessment element to help staff access the right support at the right time.

Looking After Our People

The organisation saw an increase in the overall sickness percentage in November by 0.05% to 4.79%. This increase was in short term absences however the Trust saw a further reduction in long term sickness of 0.20% to 2.28%. The top two reasons for absence continue to be Anxiety/Stress/Depression followed by Cold/Cough/Flu. Infectious diseases (which include COVID-19) dropped to reason 7; however, with 86 confirmed staff positives in December, infectious diseases as a reason for absence is expected to increase.

The onsite counselling service remains busy with continued uptake from staff. We are seeing a shift toward more staff being seen but for fewer sessions each. Waiting time for onsite counselling has reduced to ten days and urgent cases are seen within 24 to 48 hours. Alongside onsite counselling it is evident staff continue to use other support on offer, with a further increase in access to the Vivup EAP and an increase in Occupational Health referrals. The increase in Occupational Health referrals is specifically attributable to an increase in musculo-skeletal issues. This will be crossed-referenced with the information from the staff self-referral physiotherapy service to see if there are any themes or trends that need addressing.

4.0 Service Recovery

Elective Recovery Fund (ERF)

For the second half of 2021/22, the planning guidance requires a threshold of 89% of Referral to Treatment (RTT) clock stops, compared to 2019/20. A weighted methodology is applied to ensure that the case mix of activity is comparable and additional income earnt will be based against the weighted income. This will be covered in the financial report, below is the volume of clock stops as this is what impacts the performance KPI's of the waiting list.

A clock stop is where the patient is either treated or discharged and therefore is no longer on the incomplete waiting list. DCH performances well when monitored against the volume of clock stopping events.

Activity type	Target from Oct	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Clock stops	89%	94.68%	92.76%	102.82%	85.96%	97.10%	99.82%	90.20%	106.61%	108.27%

Table 1 – percentage of clock stops, by month, compared to 2019/20

Health Inequalities

Organisations are required to address the longest waiters and ensure health Inequalities are tackled throughout the plan, with a particular focus on analysis of waiting times by ethnicity and deprivation.

Analysis of patients awaiting treatment by ethnicity code is undertaken monthly. December's referral to treatment waiting list data indicates 54.91% of patients who identify as white are treated within 18 weeks. 55.19% of from an ethnic minority are treated within 18 weeks. There are 183 patients of the total waiting list from ethnic minorities, 1.07%. December's diagnostic waiting list data indicates 91.30% of patients who identify as white have their diagnostic procedure completed within 6 weeks. 87.80% of

patients from ethnic minorities have their diagnostic procedure completed within 6 weeks. There are 41 patients of the total waiting list from ethnic minorities, 0.96%.

There are several patients with an unknown ethnicity recorded on our Patient Administration System (PAS). Our Information Assurance Team continue to work with services to improve the collection of ethnic group data on PAS.

This month we can report on patients with a learning disability. We are now able to identify patients on our waiting lists with a learning disability flag. There are 119 patients on the referral to treatment waiting list with a learning disability flag. 59.66% of these patients have been treated with 18 weeks in December 2021, this compares to 55.52% for patients without a learning disability flag. There are 22 patients on the diagnostic waiting list with a learning disability flag. 77.27% of these patients have had their diagnostic procedure within 6 weeks in December 2021, this compares to 91.25% for patients without a learning disability flag.

BI Teams across the system are working on automated reporting for deprivation waiting times.

Elective Waiting List Size

In December the total waiting list size decreased by 778 patients compared to the previous month. This takes the total waiting list size to 4,446 below trajectory. Waiting list profile has had a positive change, all time bands apart from 52-77 weeks and patients waiting over 104 weeks

W/L total size	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Total W/L trajectory	17274	17171	17516	17711	17812	17599	19816	20571	21470
Total W/L actual	17194	17666	17928	18505	19089	19123	18773	17802	17024
Variance	-80	495	412	794	1277	1524	-1043	-2769	-4446

Table 2 – the total waiting list size vs trajectory, by month

At the end of December, there were 1,703 patients waiting over 52 weeks for treatment. This is an increase of 24 patients compared to the previous month and is 297 fewer than trajectory.

52+ week waiters	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
52+ww trajectory	3000	3091	3153	3188	3206	3168	2200	2100	2000	1900	1800	1700
52+ww actual	2947	2589	2386	2256	2227	2124	1911	1679	1703			
Variance	-53	-502	-767	-932	-979	-1044	-289	-421	-297			

Table 3 – the total number of 52+ week waiters vs trajectory, by month

As part of the second half of 2021/22 planning submission, a 104+ week wait trajectory was also required. At the end of December, there were 216 patients waiting over 104+ weeks, this is 1 patient more than trajectory. Our submission highlights our inability to reach zero 104+ week waiters by the end of March 2022. At the end of the financial year, we are anticipating 104+ week waiters in Orthopaedics. Regional mutual aid is currently being explored.

104+ week waiters	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
104+ww trajectory							169	192	215	109	125	138
104+ww actual	20	41	70	91	117	161	189	185	216			
Variance	20	41	70	91	117	161	20	-7	1			

Table 4 – total number of 104+week waiters vs trajectory, by month

The Trust's approach to service recovery recognises the waiting list demand outweighs service capacity and the need to not overburden staff. Both insourcing and outsourcing activity continues to be utilised.

Performance within the Region

Following the release of a new regional reporting tool, all providers in the South West are now ranked by waiting list profile. DCH is currently ranked:

- 15th out of 15 for the percentage of the waiting list that is over 52 weeks

- 15th out of 15 for the percentage of the waiting list that is over 78 weeks
- 15th out of 15 for the percentage of the waiting list that is over 104 weeks

DCH however, continues to demonstrate strong recovery, with a reduction in the number of long waiters and continued improved diagnostic performance and the gap between the ranking positions is closing.

Latest data for 9 January 2022 (All Pathways, Dated status: All)

STP	Organisation	Total Incomplete Pathways	Number of 52+ Weeks	52+ Weeks %	52+ Weeks % RANK	Number of 78+ Weeks	78+ Weeks %	78+ Weeks % RANK	Number of 104+ Weeks	104+ Weeks %	104+ Weeks % RANK
Grand Total		538,803	32,067	6.0%	1	8,027	1.5%	1	2,344	0.4%	1
BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE STP	GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	28,481	645	2.3%	1	56	0.2%	2	0	0.0%	1
	ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	30,734	1,269	4.1%	5	83	0.3%	3	2	0.0%	3
	SALISBURY NHS FOUNDATION TRUST	19,457	671	3.4%	3	133	0.7%	6	9	0.0%	5
BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE STP	NORTH BRISTOL NHS TRUST	38,272	2,307	6.0%	9	524	1.4%	7	185	0.5%	10
	UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST	53,442	3,792	7.1%	10	937	1.8%	10	284	0.5%	11
CORNWALL AND THE ISLES OF SCILLY HEALTH & SOCI..	ROYAL CORNWALL HOSPITALS NHS TRUST	36,201	1,372	3.8%	4	240	0.7%	4	43	0.1%	6
DEVON STP	NORTHERN DEVON HEALTHCARE NHS TRUST	19,183	1,362	7.1%	11	128	0.7%	5	5	0.0%	4
	ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	64,891	6,377	9.8%	14	1,886	2.9%	13	565	0.9%	13
	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	33,446	2,460	7.4%	12	542	1.6%	9	156	0.5%	9
	UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	40,548	3,014	7.4%	13	1,180	2.9%	14	427	1.1%	14
DORSET STP	DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	16,794	1,715	10.2%	15	603	3.6%	15	216	1.3%	15
	UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	52,965	2,960	5.6%	7	953	1.8%	12	293	0.6%	12
GLOUCESTERSHIRE STP	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	59,998	1,640	2.7%	2	83	0.1%	1	2	0.0%	2
SOMERSET STP	SOMERSET NHS FOUNDATION TRUST	32,267	1,755	5.4%	6	464	1.4%	8	136	0.4%	8
	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	12,124	728	6.0%	8	215	1.8%	11	21	0.2%	7

For queries please email NHSI.southwestanalytics@nhs.net

Table 5 – South West Region waiting list profile ranking by provider

South Walks House

Our multi professional clinics from South Walks House continue, working in partnership with Dorset Council and our health care colleagues to offer a range of outpatient services under one roof. These are integral to ongoing elective recovery and mitigating further elective growth. The Family Services and Surgical Division continue to work with teams to utilise space at South Walks House and community hospitals by relocating outpatient clinics from the main DCH site. The Breast Service is currently exploring the possibility of relocating to South Walks House. We are currently looking at the opportunity to secure South Walks House on a long-term basis to enable further service recovery whilst also addressing and unlocking other strategic infrastructure requirements including the new Emergency Department and Intensive Care Unit.

5.0 Summary

The health and wellbeing of our people is our priority. We are invested in delivering initiatives and practices to support our people through listening and learning from lived experiences. This is key to supporting their recovery following the pandemic. Recruiting, retaining, and developing people is vital to the recovery of services.

The organisation's waiting list profile ranking in the Region is not ideal however, the significant reduction in 52+ week waiters beyond trajectory is pleasing. Recognising the mismatch in capacity and the demand of services we continue to utilise insourcing and outsourcing of activity, not to overburden our people.

Meeting Title:	**Board of Directors Part One**
Date of Meeting:	**26th January 2022**
Document Title:	**Performance Scorecard and Board Sub-Committee Escalation Reports**
Responsible Director:	**Executive Team**
Author:	**Abi Baker, Governance Support Officer**

Confidentiality:	No
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Finance and Performance Committee (performance metrics)	18th January 2022	See committee escalations

Purpose of the Paper	To provide the Board with details of the Trust's operating performance, and to escalation key issues from the Board Sub Committees to the Board of Directors.							
	Note (✓)	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	**Performance Scorecard** Key areas for operational standards in December 2021: The Trust did meet the standard for: • 52+ week wait trajectory • Waiting list size trajectory • 31 day standards for 1st Treatment and Subsequent treatments The Trust did not meet the standards for: • Zero 52 week waits • Zero 104 week waits • RTT performance percentage • Diagnostic Waiting Times • ED, DCH only and Combined with MIU • All Cancers - 62 Day Referral to Treatment following an urgent GP referral • Two week wait from referral to first seen • Breast Symptomatic Two Week Wait from urgent GP referral to first seen • All Cancers - 31 Day Subsequent Treatment (Surgery) • 104+ week wait trajectory Looking forward to January 2022, it is anticipated that DCH will meet the standards for: • Cancer 31 days (except surgery) • 52+ week wait trajectory • Waiting list size trajectory DCH will not meet the standard in January for:							

	• RTT • 104+ week wait trajectory • Diagnostic Waiting Times • ED – 4 hour standard combined with MIU • Cancer 62 day standard • Cancer two week wait standard • Cancer Breast symptomatic 2 week wait • Zero 52 week waits • Zero 104 week waits • Cancer- 31 day where treatment is surgery DCH is currently on track to deliver against all agreed H2 trajectories by March 2022, apart from the 104+ week wait metric. The trajectories can be found in the body of the paper. **Escalation Reports** The January Board sub-committees met as follows: Monday 17th January: People and Culture Committee Tuesday 18th January: Quality Committee, Finance and Performance Committee, Risk and Audit Committee. The attached reports detail the significant risks and issues for escalation to Board for action, key issues discussed, decisions made, implications for the Corporate Risk Register and Board Assurance Framework (BAF), and items for referral to other committees, arising from each of the Board sub-committee meetings.
Action recommended	The Board of Directors is requested to: 1. **NOTE** the performance data 2. **NOTE** the escalations from the Board sub-committees.

Governance and Compliance Obligations

Legal / Regulatory	N	
Financial	N	
Impacts Strategic Objectives?	Y	Operational performance and corporate governance underpins all aspects of the Trust's strategic objectives.
Risk?	Y	Implications for the Corporate Risk Register or the Board Assurance Framework (BAF) are outlined in the escalation reports.
Decision to be made?	N	Details of decisions made are outlined in the committee escalation reports.
Impacts CQC Standards?	Y	Operational performance and governance underpins all aspects of the CQC standards.
Impacts Social Value ambitions?	Y	Operational performance and corporate governance underpins all aspects of the Trust's social value ambitions.
Equality Impact Assessment?	N	N/A
Quality Impact Assessment?	N	N/A

Metric	Threshold/ Standard	Type of Standard	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Q1	Q2	Q3	YTD	Movement on Previous Period	12 Month Trend
Safe														
Infection Control - MRSA bacteraemia hospital acquired post 48hrs (Rate per 1000 bed days)	**0**	Contractual (National Quality Requirement)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	↔	
Infection Control - C-Diff Hospital Onset Healthcare Associated (Rate per 1000 bed days)	**22**	Contractual (National Quality Requirement) 2019/20	2 (0.2)	5 (0.6)	5 (0.6)	3 (0.3)	6 (0.7)	6 (0.6)	9 (0.4)	12 (0.5)	15 (0.5)	36 (0.5)	↔	
NEW Harm Free Care (Safety Thermometer)	**95%**	Local Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**N/A**	
Never Events	**0**	Contractual (National Requirement)	0	0	0	0	1	0	0	0	0	1	↑	
Serious Incidents investigated and confirmed avoidable	**N/A**	For monitoring purposes only	2	0	0	0	0	1	0	2	1	3	**N/A**	
Duty of Candour - Cases completed	**N/A**	For monitoring purposes only	7	7	9	10	9	3	26	23	22	71	**N/A**	
Duty of Candour - Investigations completed with exceptions to meet compliance	**N/A**	For monitoring purposes only	0	0	0	0	0	0	0	0	0	0	**N/A**	
NRLS - Number of patient safety risk events reported resulting in severe harm or death	**10% reduction 2016/17 = 21.6 (1.8 per mth)**	Local Plan	3	3	0	1	3	0	6	6	4	16	↑	
Number of falls resulting in fracture or severe harm or death (Rate per 1000 bed days)	**10% reduction 2016/17 = 9.9**	Local Plan	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	↔	
Pressure Ulcers - Hospital acquired (category 3) confirmed reportable (Rate per 1000 bed days)	**N/A**	For monitoring purposes only	1 (0.1)	0 (0.0)	0 (0.0)	2 (0.2)	0 (0.0)	0 (0.0)	1 (0.0)	1 (0.0)	2 (0.0)	4 (0.1)	↔	
Emergency caesarean section rate			17.5%	N/A	N/A	N/A	N/A	N/A	22.6%	N/A	N/A	21.9%	↑	
Sepsis Screening - percentage of patients who met the criteria of the local protocol and were screened for sepsis (**ED**)	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	89.1%	95.5%	88.6%	N/A	N/A	N/A	95.0%	90.3%	N/A	92.8%	↓	
Sepsis Screening - percentage of patients who met the criteria of the local protocol and were screened for sepsis (**INPATIENTS** - collected from April 2017)	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	97.7%	89.5%	87.5%	96.4%	87.2%	N/A	92.6%	91.8%	92.6%	92.3%	↑	
Sepsis Screening - percentage of patients who were found to have sepsis and received IV antibiotics within 1 hour (**ED**)	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	88.9%	87.5%	83.3%	N/A	N/A	N/A	84.9%	86.6%	N/A	85.7%	↓	
Sepsis Screening - percentage of patients who were found to have sepsis and received IV antibiotics within 1 hour (**INPATIENTS** - collected from April 2017)	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	89.2%	100%	100%	79.5%	87.1%	N/A	87.5%	95.9%	82.9%	89.4%	↑	
Effective														
SHMI Banding (deaths in-hospital and within 30 days post discharge) - Rolling 12 months [source NHSD]	**2 ('as expected') or 3 ('lower than expected')**	Contractual (Local Quality Requirement)	1	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↑	**N/A**
SHMI Value (deaths in-hospital and within 30 days post discharge) - Rolling 12 months [source NHSD]	**≤1.14 (ratio between observed deaths and expected deaths)**	Contractual (Local Quality Requirement)	1.15	1.12	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↑	
Mortality Indicator **HSMR** from Dr Foster - Rolling 12 months	**100**	Contractual (Local Quality Requirement)	100.6	101.3	103.1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↓	
Mortality Indicator **Weekend Non-Elective HSMR** from Dr Foster - Rolling 12 months	**100**	Contractual (Local Quality Requirement)	99.5	101.6	106.2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↓	
Stroke - Overall SSNAP score	**C or above**	Contractual (Local Quality Requirement)	C			N/A	N/A	N/A	N/A	N/A	N/A	N/A	↓	**N/A**
Dementia Screening - patients aged 75 and over to whom case finding is applied within 72 hours following emergency admission	**90%**	Contractual (Local Quality Requirement)	64.6%	63.7%	49.6%	89.9%	90.2%	80.4%	58.3%	64.2%	89.9%	63.0%	↓	
Dementia Screening - proportion of those identified as potentially having dementia or delirium who are appropriately assessed	**90%**	Contractual (Local Quality Requirement)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	↔	
Dementia Screening - proportion of those with a diagnostic assessment where the outcome was positive or inconclusive who are referred on to specialist services	**90%**	Contractual (Local Quality Requirement)	90.9%	85.7%	83.7%	89.8%	98.0%	94.7%	80.9%	88.0%	84.4%	84.4%	↓	
Caring														
Compliance with requirements regarding access to healthcare for people with a learning disability	**Compliant**	For monitoring purposes only	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	↔	
Complaints - Number of formal & complex complaints	**N/A**	For monitoring purposes only	32	48	34	26	36	19	64	114	81	204	↑	
Complaints - Percentage response timescale met	**Dec '18 = 95%**	Local Trajectory	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	↔	
Friends and Family - Inpatient - Recommend	**96%**	Mar-18 National Average	94.2%	92.5%	95.1%	93.1%	93.8%	93.5%	93.9%	94.0%	93.1%	93.8%	↓	
Friends and Family - Emergency Department - Recommend	**84%**	Mar-18 National Average	85.8%	82.7%	86.4%	86.2%	86.8%	87.9%	86.9%	85.0%	86.2%	86.2%	↑	
Friends and Family - Outpatients - Recommend	**94%**	Mar-18 National Average	91.9%	92.8%	93.3%	93.3%	93.8%	93.8%	93.6%	92.7%	93.3%	93.3%	↑	
Number of Hospital Hero Thank You Award applications received	**2016/17 = 536 (44.6 per month)**	Local Plan (2016/17 outturn)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↔	

Metric	Threshold/ Standard	Type of Standard	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Q1	Q2	Q3	YTD	Movement on Previous Period	12 Month Trend
Responsive														
Referral To Treatment Waiting Times - % of incomplete pathways within 18 weeks (QTD/YTD = Latest 'in month' position)	**92%**	Contractual (National Operational Standard)	**57.1%**	**57.2%**	**56.5%**	**55.4%**	**56.1%**	**55.6%**	**56.4%**	**56.5%**	**55.4%**	**55.4%**	↓	
RTT Incomplete Pathway Waiting List size	**Trajectory Dec = 17813**		**18505**	**19089**	**19120**	**18773**	**17802**	17024	**17928**	**19120**	17024	17024	↑	
Cancer (ALL) - 14 day from urgent gp referral to first seen	**93%**	Contractual (National Operational Standard)	**55.8%**	**44.3%**	**59.7%**	**38.1%**	**52.9%**	**63.5%**	**67.0%**	**52.7%**	**51.1%**	**56.9%**	↑	
Cancer (Breast Symptoms) - 14 day from gp referral to first seen	**93%**	Contractual (National Operational Standard)	**9.4%**	**9.4%**	**52.5%**	**7.0%**	**52.2%**	**60.7%**	**4.5%**	**24.2%**	**46.5%**	**25.1%**	↑	
Cancer (ALL) - 31 day diagnosis to first treatment	**96%**	Contractual (National Operational Standard)	97.3%	96.4%	98.5%	**92.3%**	96.9%	97.8%	96.1%	97.4%	**95.5%**	96.3%	↑	
Cancer (ALL) - 31 day DTT for subsequent treatment - Surgery	**94%**	Contractual (National Operational Standard)	100.0%	**92.3%**	**92.3%**	100.0%	100.0%	100.0%	**93.9%**	**93.8%**	100.0%	95.9%	↔	
Cancer (ALL) - 31 day DTT for subsequent treatment - Anti-cancer drug regimen	**98%**	Contractual (National Operational Standard)	100.0%	100.0%	100.0%	100.0%	**97.4%**	100.0%	100.0%	100.0%	98.9%	99.6%	↑	
Cancer (ALL) - 31 day DTT for subsequent treatment - Other Palliative	**98%**	Contractual (National Operational Standard)	-	-	100.0%				-				↔	
Cancer (ALL) - 62 day referral to treatment following an urgent referral from GP (post)	**85%**	Contractual (National Operational Standard)	**74.0%**	**70.5%**	**72.1%**	**70.7%**	**80.8%**	**63.6%**	**76.5%**	**72.2%**	**72.2%**	**73.6%**	↓	
Cancer (ALL) - 62 day referral to treatment following a referral from screening service (post)	**90%**	Contractual (National Operational Standard)	**80.0%**	**68.8%**	**70.6%**	**76.5%**	**71.4%**	**87.5%**	**65.7%**	**73.6%**	**76.9%**	**72.1%**	↑	
% patients waiting less than 6 weeks for a diagnostic test	**99%**	Contractual (National Operational Standard)	**85.4%**	**86.3%**	**92.4%**	**94.8%**	**95.7%**	**91.2%**	**81.0%**	**87.8%**	**94.8%**	**84.3%**	↓	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge	**95%**	Contractual (National Operational Standard)	**63.9%**	**61.1%**	**64.0%**	**60.3%**	**61.5%**	**60.3%**	**75.2%**	**62.9%**	**60.3%**	**69.2%**	↓	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (including MIU/UCC activity from November 2016)	**95%**	Contractual (National Operational Standard)	**76.9%**	**75.4%**	**76.3%**	**72.6%**	**74.0%**	**72.0%**	**82.9%**	**76.2%**	**72.6%**	**79.5%**	↓	
Well Led														
Annual leave rate (excluding Ward Manager) **% of weeks within threshold**	**11.5 - 17.5%**		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sickness rate (one month in arrears)	**3.3%**	Internal Standard reported to FPC	**4.18%**	**4.59%**	**4.38%**	4.77%	4.79%	N/A	**3.4%**	**4.38%**	4.78%	**4.1%**	↓	
Appraisal rate	**90%**	Internal Standard reported to FPC	**76%**	**75%**	**72%**	**72%**	**71%**	**69%**	**78%**	**74%**	**71%**	**74%**	↓	
Staff Turnover Rate	**8 -12%**	Internal Standard reported to FPC	8.3%	8.2%	7.6%	8.5%	8.1%	8.7%	8.0%	8.0%	8.40%	8.2%	↓	
Total Substantive Workforce Capacity		Internal Standard reported to FPC	2,765.2	2,790.0	2,819.8	2,837.0	2,875.4	2,881.0	2,790.6	2,791.7	2,864.5	2,815.6	**N/A**	
Vacancy Rate (substantive)	**<5%**	Internal Standard reported to FPC	**7.6%**	**6.8%**	**6.6%**	**5.7%**	**5.3%**	**6.3%**	**7.4%**	**7.0%**	**5.8%**	**6.7%**	↓	
Total Substantive Workforce Pay Cost		Internal Standard reported to FPC	**11,004.0**	**11,385.9**	**12,443.5**	**11,378.7**	**11,601.2**	**11,692.1**	**11,141.7**	**11,611.1**	**11,557.3**	**11,428.1**	↓	
Number of formal concerns raised under the Whistleblowing Policy in month	**N/A**	Internal Standard reported to FPC	0	0	0	0	0	0	0	0	0	0	**N/A**	
Essential Skill Rate	**90%**	Internal Standard reported to FPC	**88%**	90%	**89%**	**89%**	**89%**	90%	**88%**	**89%**	**89%**	**89%**	↑	
Elective levels of contracted activity (activity)	**2019/20 = 30,584 2548/month**		**2,145**	**1,953**	**2,217**	**2,192**	**2,285**	**1,923**	**6,490**	**6,315**	**6,400**	**19,205**	↓	
Elective levels of contracted activity (£) Including MFF	**2019/20 = £30,721,866 £2,560,155/month**		**£2,383,547**	**£1,952,439**	**£2,299,055**	**£2,128,472**	**£2,422,512**	**£2,111,397**	**£6,872,694**	**£6,635,041**	**£6,662,381**	**£20,170,116**	↓	
Surplus/(deficit) (year to date)	**2021/22 = £349 YTD M9 = £(432)**	Local Plan	**(602)**	**(570)**	**(592)**	**(1,215)**	**(721)**	**(578)**	**(717)**	**(592)**	**(578)**	**(578)**	**N/A**	**N/A**
Cash Balance	**2021/22 - M9 = 13,763**		17,527	16,964	14,761	20,591	17,291	17,369	15,841	14,761	17,369	17,369	↑	
CIP - year to date (aggressive cost reduction plans)	**H2 target - £1,506 M7 target £822k**	Local Plan	N/A	N/A	N/A	231	Yet to be decided	Yet to be decided	N/A	N/A	N/A	N/A	**N/A**	**N/A**
Agency spend YTD	**2021/22 = No Annual value YTD M9 = £6,109**		**4,272**	**5,375**	**6,338**	**7,328**	**8,207**	**9,032**	**3,206**	**6,338**	**9,032**	**9,032**	**N/A**	**N/A**
Agency % of pay expenditure			**8.4%**	**8.4%**	**8.1%**	**7.5%**	**7.8%**	**7.7%**	**8.3%**	**8.4%**	**7.7%**	**7.7%**	↓	

Movement Key

Favourable Movement ↑

Adverse Movement ↓

Achieving Standard

Not Achieving Standard

Key Performance Metrics Summary

	Metric	Standard	Nov-21	Dec-21
Quality	MRSA hospital acquired cases post 48hrs (Rate per 1000 bed days)	**0**	0 (0.0)	0 (0.0)
	E-Coli hospital acquired cases (Rate per 1000 bed days)	**81**	3 (0.3)	0 (0.0)
	Infection Control - C-Diff Hospital Onset Healthcare Associated (Rate per 1000 bed days)	**22**	**6 (0.7)**	**6 (0.6)**
	Never Events	**0**	**1**	0
	Serious Incidents declared on STEIS (confirmed)	**51 (4 per month)**	0	1
	SHMI - Rolling 12 months (Jul-20 to Jun-21)	**<1.14**	1.12	
	Mortality Indicator HSMR from Dr Foster - Rolling 12 months (Apr-20 to Mar-21)	**100**	**103.1**	
Performance	RTT incomplete pathways within 18 weeks (Quarter/Year = Lowest 'in month' position)	**92%**	**56.1%**	**55.6%**
	RTT Incomplete Pathway Waiting List size	**Trajectory Dec = 17813**	**17,802**	17,024
	All cancers maximum 62 day wait for first treatment from urgent GP referral	**85%**	**80.8%**	**63.6%**
	Maximum 6 week wait for diagnostic tests	**99%**	**95.7%**	**91.2%**
	ED maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from November 2016)	**95%**	**74.0%**	**72.0%**
Finance	Elective levels of contracted activity (£)	**2019/20 = £30,721,866 £2,560,155/month**	**2,422,512**	**2,111,397**
	Surplus/(deficit) (year to date)	**2021/22 = £349 YTD M9 = £(432)**	**(721)**	**(578)**
	CIP - year to date (aggressive cost reduction plans)	**H2 target - £1,506 M7 target £822k**	Yet to be decided	Yet to be decided
	Agency spend YTD	**2021/22 = No Annual value YTD M9 = £6,109**	**8,207**	**9,032**

Rating Key

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: 20th December 2021

Presented by: Margaret Blankson

Significant risks / issues for escalation to Board for action	• Level 3 Safeguarding training compliance and plan to improve • Transforming People Practice Update – see below • The Emergency Department won three out of six possible awards at the Inaugural Wessex Innovation and Excellence Awards the previous week. • Divisional workforce gaps and work to better understand these.
Key issues / other matters discussed by the Committee	The committee received, discussed and noted the following reports: • People Performance Report and Dashboard noting the rapidly changing COVID picture which was impacting on staffing with increasing sickness absence, the completion by the first cohorts of the Inclusive Leadership Programme, a static appraisal compliance rate and a good response to the national Staff Survey • Family and Surgical Service Divisional Report noting a reduction in mandatory training compliance and a system-wide approach to addressing recruitment for some difficult to recruit to posts. The first iteration of the Divisional Dashboard was also presented. • Transforming People Practice Update noting the successful trial of Values base recruitment for Band 2 posts, the involvement of locally employed medical staff in medical staff appraisal and the redesigned Disciplinary Policy. • Education, Training and Development report noted difficulties spending development finding this year, successful registration of the July cohort of overseas nurses with the Nursing and Midwifery Council and a reduction in level 3 Safeguarding training compliance. • The establishment of two new Staff Networks – the Armed Forces Network and the Overseas Staffing Network.
Decisions made by the Committee	• The Guardian of Safe Working Hours Reporting schedule was approved ensuring compliance with contractual reporting requirements going forward.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Further work to be undertaken to explore workforce risks at speciality level, the impact of these on the Elective Recovery Programme and links with Quality Committee.
Items / issues for referral to other Committees	• Impact of workforce gaps on service quality and safety – currently being explored further.

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Quality Committee

Date of Meeting: 21st December 2021

Presented by: Judy Gillow / Nicky Lucey

Significant risks / issues for escalation to Board for action	• One Never-Event and one possible Never Event (to be confirmed) reported in November • Risks relating to delays in patient attendance at hospital due to Covid-19 • Continuing review of Ockenden action plan, and key maternity risks • Pressures on staff and staff wellbeing, particularly in the admissions service

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality and Safety Performance Report noting:
	  ○ Introduction of retrospective reporting of pressure ulcers. Review of documentation and assessment to prevent pressure ulcers
	  ○ Sustained trajectory in pressure ulcers and infection prevention and control
	  ○ Reduction in falls, with none resulting in severe harm or death
	  ○ Learning from a medication incident Never-Event has been disseminated to staff
	• Maternity Safety Update noting that there were currently a number of risks in the unit; assurances were provided for these
	• Infection Prevention and Control Guidance Update highlighted the emphasis of PPE in high-risk areas and changes to guidance for staff in contact with Covid-19 cases
	• Divisional Exception Reports from
	  ○ Urgent and Integrated Care Division noting the risks relating to delays in patient attendance at hospital due to Covid-19
	  ○ Family and Surgical Services Division also noting the above risks, and possible surgery related Never-Event
	• Sub-Committee Minutes and Escalations were noted from
	  ○ Safeguarding Group
	  ○ Medicines Committee
	  ○ Infection Prevention and Control Group

Decisions made by the Committee	• Nil
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil new
Items / issues for referral to other Committees	• Poor compliance with Child Safeguarding Level 3 training

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Finance and Performance Committee

Date of Meeting: 21st December 2021

Presented by: Stephen Tilton (Chair)

Significant risks / issues for escalation to Board for action	• Increased focus on patient flow and reducing the number of patients in hospital with 'no reason to reside' • Improvements in the wating list and reduction in the number of people waiting in excess of 104 weeks • Clinical coding issues and improvement work ongoing.

Key issues / other matters discussed by the Committee	The Committee received, discussed and noted the following reports and updates:
	• Performance Report noting reductions in waiting list sizes and support and information for cancer patients waiting longer than two weeks.
	• Finance Report and level of confidence in achieving a year end breakeven position, the Cash Flow forecast and H2 plan
	• ED15 Update
	• Divisional Exception Reporting
	  ○ Urgent and Integrated Care
	  ○ Family Services and Surgical Services
	• An update on the Clinical Coding position noting the need for further discussion in January 2022
	• Estates Statutory Compliance Report and Travel working Group Update
	• Strategic Estates Masterplan Update

Decisions made by the Committee	The following items were approved by the committee: • Business Planning Process for 2022/23 • Pathology Hub shortfall subject to a fixed price arrangement. • HR recruitment Investment
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Risks discussed are contained within the Risk Register.
Items / issues for referral to other Committees	• The People and |Culture Committee would monitor process improvement measures arising from the investment case within the Recruitment team

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: 17th January 2022

Presented by: Margaret Blankson

Significant risks / issues for escalation to Board for action	• Workforce Planning Report and the wider system work focussing on staff retention across a variety of forums and covering a range of staff groups. • Support for international recruits in terms of accommodation, family visas and staff retention at the end of their initial contractual period. • Bank and Agency Usage Report noting increased Bank usage and a slight reduction in Agency Expenditure
Key issues / other matters discussed by the Committee	The committee received, discussed and noted the following reports: • Child Safeguarding Training Report noting no service practice concerns and a return to 90% level 3 training compliance, the launch of the Overseas Staff Network later in the month and reduction in Agency expenditure • People Performance Report and Dashboard noting increasing levels of sickness absence • Urgent and Integrated Care Divisional Report • The Business Intelligence / Health Informatics Report was deferred to February • Workforce Planning Update • Improving the Experiences of International Nurses Report noting the need to ensure the availability of suitable accommodation and support for staff to find alternative accommodation following their initial period • Bank and Agency Usage Report noted a reduction in Agency Expenditure and that there had been no Red Flag staffing incidents in December. However, capacity in some services had been capped on occasion. •
Decisions made by the Committee	• None
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The Workforce Risk Report was deferred.
Items / issues for referral to other Committees	• None

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Quality Committee

Date of Meeting: 18th January 2022

Presented by: Judy Gillow / Nicky Lucey

Significant risks / issues for escalation to Board for action	• Mixed-sex accommodation levels remain a challenge • Positive feedback from patients • Sustained quality improvement in pressure ulcers and falls • Continued pressures in the maternity unit • An inspection of Blood Sciences by MRHA identified urgent actions to be completed within 7 days and possible governance concerns within the service

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality and Safety Performance Report noting:
	  ○ Continuing positive trends in infection prevention and control, pressure ulcers and falls and patient feedback
	  ○ Challenges of mixed-sex accommodation
	• Maternity Education and Training Report noting
	  ○ Reinvigorated training in line with national guidance, with good attendance at this training
	  ○ The challenge to provide the training requirements from Ockenden, estimated at 4 full days training per year for each member of staff
	• Maternity Safety Report noting
	  ○ The maternity service remains safe, and morale is good despite the pressures they are under
	  ○ Potential health inequality issue of women not being able to access BadgerNet due to lack of phone credit
	  ○ No formal complaints for the service since October
	• Divisional Exception Reports from
	  ○ Urgent and Integrated Care Division noting an audit on Blood Sciences by MRHA with some urgent actions. Issues with the CPAP service in Salisbury have been escalated to Bath Somerset and Wiltshire CCG
	  ○ Family and Surgical Services Division noting updates on recent Never Events and the clinical typing backlog
	• Sub-Committee Minutes and Escalations were noted from
	  ○ Nil received

Decisions made by the Committee	• Nil
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil

Items / issues for referral to other Committees	• Maternity Education and Training report to be presented to People and Culture Committee on an annual basis

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Finance and Performance Committee

Date of Meeting: 18th January 2022

Presented by: Stephen Tilton (Chair)

Significant risks / issues for escalation to Board for action	• Increased focus on patient flow and reducing the number of patients in hospital with 'no reason to reside' – currently 22%. • Stabilisation of the wating list in respect of those people waiting 52 and 104 weeks for assessment and treatment. • Clinical coding issues and improvement work ongoing.

Key issues / other matters discussed by the Committee	The Committee received, discussed and noted the following reports and updates:
	• Performance Report noting continuing high bed occupancy rates, patient flow difficulties, a high percentage of patients with no reason to reside (22%), stabilisation of the 52 and 104 week waiting lists
	• Finance Report noting Year to Date performance was in line with the plan and increasing confidence that the year-end break even position would be achieved.
	• Divisional Exception Reporting
	  ○ Urgent and Integrated Care
	  ○ Family Services and Surgical Services noting an update on theatre utilisation and work on cultural development to be returned to the committee in the spring.
	• DCH Subco Escalation Report noting risks arising from increased activity and limited capacity
	• ED 15 Update
	• DCH Subco Quarterly Performance Report

Decisions made by the Committee	The following items were approved by the committee: • South Walks House Lease • Clinical Coding Imperative noting an action plan to be returned to the Senior Leadership group • International Recruitment Update progressing recruitment of an additional 35 recruits • Nuance Speech Recognition Contract
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• DCH Subco risks to continued safety of service provision
Items / issues for referral to other Committees	•

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Risk and Audit Committee

Date of Meeting: 18th January 2022

Presented by: Stuart Parsons

Significant risks / issues for escalation to Board for action	• MHRA risk and action plan
Key issues / other matters discussed by the Committee	The committee received and noted the following reports: • Internal Audit Progress Report, significant assurance on recruitment process design and moderate assurance on effectiveness received. Timely completion of follow up recommendations from previous audits • The draft Internal Audit Plan 2022/23 was noted. The committee noted further consideration of organisational development and wellbeing audits for inclusion and the final draft plan to be returned to the committee in March 2022 for approval. • External Audit Progress Report and preparatory work to support the annual audit of the Annual Report and Accounts. • Board Assurance Framework and the development of risks therein. Additionally, the embedding of a regular review process and the strength of assurances and controls to be considered for inclusion going forward. • A verbal update on the Corporate Risk Register was received
Decisions made by the Committee	The committee approved the following: • Internal Audit Progress Report
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• There was no written Corporate Risk Register Report this would be produced and circulated post meeting. • MHRA risk and action plan to the added to the Corporate Risk Register
Items / issues for referral to other Committees	• Refer recruitment KPIs to People and Culture Committee to monitor improvements.

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Charitable Funds Committee

Date of Meeting: 15 December 2021 (reports for information only, via email)

Presented by: Dave Underwood

Significant risks / issues for escalation to Committee / Board for action	• Dorset County Hospital Charity finances impacted by pandemic, as per UK charity sector. DCH Charity Financial Review (Q3) will be held by the DCH Charity Strategy Group on 1.2.22
Key issues / matters discussed at the Committee	Charitable Funds Committee due to be held on 15.12.21 was cancelled due to current DCH operational priorities. Standing reports were circulated via email to committee. Reports circulated included: • **DCH Charity Finance/Income** reports (M7 Oct 2021) - DCHC Finance report (M7) - DCHC Income report (M7) - DCHC Fund balance/reserves report (M7) - DCHC funding commitments report (M7) • **DCH Fundraising & Communications update report** • **DCH Arts in Hospital Manager's report (including AiH temporary exhibitions programme 2021-22)**
Decisions made by the Committee	• No decisions made as reports circulated for information only.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil
Items / issues for referral to other Committees	None

Meeting Title:	Board of Directors
Date of Meeting:	26 January 2022
Document Title:	**Dorset Integrated Care System Overview**
Responsible Director:	Nick Johnson, Interim Chief Executive
Author:	Natalie Violet, Corporate Business Manager to the Chief Executive

Confidentiality:	Not confidential
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Interim Chief Executive	19/01/2022	Approved

Purpose of the Paper	The purpose of this report is to provide the Board of Directors with an overview of the Dorset Integrated Care System from a performance, quality, and finance perspective.							
	Note	✓	*Discuss*		*Recommend*		*Approve*	
Summary of Key Issues	Highlights include: Performance: • Emergency activity remains high with SWAST being on the highest level of alert since mid-June. • Bed flow across the system is challenged with increasing numbers of delayed discharges. An increase in COVID positive inpatients and suspensions of care homes due to COVID is exacerbating flow issues. • The referral to treatment waiting list size has increased and is not in line with trajectory. Weekly meetings are taking place with NHS England. However, the system saw a reduction of 246 patients waiting in excess of 52 weeks. • The system continues to be the best performing in region for diagnostic performance. • Cancer performance continues to be challenged with a significant increase in two week wait referrals. Despite this the Wessex Cancer Alliance have the lowest number of patients waiting over 62 days when compared nationally. Quality: • The system has seen an increase in COVID-19 outbreaks reported in hospital sites and care homes. Learning is being shared and improvement plan completed and system support is in place for care homes. • Coding issues, at Dorset County Hospital, have caused an increase in the Summary Hospital-level Mortality Indicator (SHMI), taking the rate above the expected level which is being investigated and further work will be undertaken to rectify the issues. • Progress to address issues with the new pathology and radiology report system has been made at University Hospitals Dorset and assurance is improving. Work is underway with the external provider to establish and address the issue with episode failures. • In Primary Care investment from the Improved Access Funds is being explored to include work around phlebotomy, catch-up from the impact of the pandemic, and possible investments into mental health services and resources. • A project in Weymouth and Portland Primary Care Network is focused on increasing update of Learning Disability Annual Health Checks in 14 – 19-							

	year-olds. The project has resulted in an increase in Learning Disability registers by approximately 10%. • In safeguarding Ofsted inspectors awarded Dorset County Council a rating of GOOD in their recent inspection of Local Authority Children's Services visit. Finance: • On 18 November 2021 the NHS organisations submitted the financial plan for the second half of this financial year, delivering the required breakeven position. All organisations are expecting to deliver the breakeven position for the financial year, as planned. • The modified financial regime for the second half of 2021/22 has increased the financial risk to the NHS bodies, with a total of £29.8M of risks identified. • The system expects to achieve £16.3M Elective Recovery Fund income in the second half of 2021/22, matched by expenditure of the same amount, in addition to the first half of 2021/22 achievement. If the levels of income earned are not as planned there is a risk that the expenditure will have been committed and therefore not fully offset by income, leaving a cost pressure. • The NHS system delivered £5.0M efficiency savings in the first half of 2021/22 but to achieve a balanced financial position for the second half of the year requires delivery of £29.8m. This increase is reflective of the increased national expectation on all systems, including a greater level of savings required for those that had a deficit position pre-COVID. • Although the system has achieved a breakeven plan for 2021/22 there remains a significant underlying deficit of £139.3M.
Action recommended	The Trust Board is recommended to: 1. **Note** the information provided.

Governance and Compliance Obligations

Legal / Regulatory	N	
Financial	N	
Impacts Strategic Objectives?	N	
Risk?	N	
Decision to be made?	N	
Impacts CQC Standards?	N	
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Title of Meeting	Board of Directors
Date of Meeting	26 January 2022
Report Title	**Dorset Integrate Care System Overview**
Author	Natalie Violet, Corporate Business Manager to the Chief Executive
Responsible Executive	Nick Johnson, Interim Chief Executive

1.0 Introduction

The purpose of this report is to provide the Board of Directors with an overview of the Dorset Integrated Care System from a performance, quality, and finance perspective.

The information is taken from meeting papers from the Dorset System Senior Leadership Team meeting held on 16 December 2021.

2.0 Performance

Emergency attendance activity continues to be in line with 2019 levels but below 2020. 999 activity continues to be significantly higher than both the previous years and SWASFT have been at highest alert level (REAP Black) since mid-June. Significant pressure remains and the system continues to experience increased levels of handover delays beyond 30 minutes. Improvements have been made in waits in excess of 4 hours at Dorset County Hospital and Poole Emergency Departments however exponential growth has been seen at Bournemouth.

Hospital bed occupancy continues to be largely above 95% mainly due to a high proportion of patients who do not meet the clinical criteria to reside. The Discharge & Flow Cell is focusing on this area and the main goal is to create flow through community hospitals to allow patients to step-down from the acutes. Block-booked beds have also been put in place to assist with discharges. Further proposals are in progress and additional investment of £3.6M non-recurrent funding has been secured.

Increasing COVID positive numbers within our hospitals is having an impact on flow together with increasing COVID suspensions at Care Homes. Dorset Healthcare are supporting patient flow in the system by converting community hospital beds for new healthcare acquired infections of COVID-19 positive care home residents who cannot return to their care home until a 14-day isolation period is complete.

The referral to treatment waiting list increased in October by 1,476 patients (2.05%). This was attributed to all providers including independent sector organisations providing NHS services. Increases were seen across all pathways with the exception of Urology. The system saw a reduction in patients waiting over 52 weeks in October, by 246 patients.

The total waiting list size is not in line with trajectories. Resulting in the risk of targets set out by NHS England for the second half of 2021/22 not being achieved. Weekly review of risks, plans, and impact are taking place with NHS England.

In diagnostic performance the waiting list increased by 794 in October however those waiting over six weeks reduced by 0.6%. The Dorset system remains as top performing in the region.

Cancer performance is challenged, there has been a significant increase in two week wait referral numbers across both acute providers. This is having an impact on the total number of patients on the PTL. The backlog of patients waiting over 62 days remains a challenge for both organisations however when compared nationally the Wessex Cancer Alliance continues to have the lowest number of patients waiting over 62 days.

The full system performance report can be found in Appendix A.

3.0 Quality

There has been an increase in COVID-19 outbreaks reported in hospital sites and care homes. Learning is being shared and improvement plan completed. Incident Management Team meetings have been held for outbreaks involving more than five cases in care homes to ensure system support is in place.

Face to face quality assurance focused visits to care homes within Dorset are ongoing with 48% of all nursing home visits completed. Visits are balanced with outbreak support to ensure care homes are not over-visited.

Coding issues, at Dorset County Hospital, have caused an increase in the Summary Hospital-level Mortality Indicator (SHMI), taking the rate above the expected level which is being investigated and further work will be undertaken to rectify the issues.

Progress to address issues with the new pathology and radiology report system has been made at University Hospitals Dorset and assurance is improving. Work is underway with the external provider to establish and address the issue with episode failures.

Meetings to monitor progress and obtain assurance to address concerns with the timeliness and quality of discharge summaries have commenced at University Hospitals Dorset. The Trust plans to address concerns and manage the significant backlog.

In Primary Care investment from the Improved Access Funds is being explored to include work around phlebotomy, catch-up from the impact of the pandemic, and possible investments into mental health services and resources.

A project in Weymouth and Portland Primary Care Network is focused on increasing update of Learning Disability Annual Health Checks in 14 – 19-year-olds. The project has resulted in an increase in Learning Disability registers by approximately 10%. The aim is to encourage the roll out across Dorset.

In Infection Control, an NHS England and Improvement South West Infection Prevention Control Collaborative commenced in November with representatives from each Dorset organisation. The aim of the collaborative was to become familiar with the use of appropriate quality improvement tools and techniques to allow change within the system. A focus on quality improvement for MSSA has been chosen for the system group.

Deputy Director for IPC Sally Matravers from NHS England and Improvement joined the System Post Infection Review meeting. The feedback was extremely positive, highlighting the system processes in Dorset as being a step ahead in innovation and robustness.

In safeguarding Ofsted inspectors awarded Dorset County Council a rating of GOOD in their recent inspection of Local Authority Children's Services visit.

The full system quality report can be found in Appendix A.

4.0 Finance

On 18 November 2021 the NHS organisations submitted the financial plan for the second half of this financial year, delivering the required breakeven position. All organisations are expecting to deliver the breakeven position for the financial year, as planned.

The modified financial regime for the second half of 2021/22 has increased the financial risk to the NHS bodies, with a total of £29.8M of risks identified. These risks include delivery of efficiency schemes and of not achieving the expected level of Elective Recovery Fund income as well as cost pressures such as prescribing and Personal Health Commissioning.

Dorset Council have reported their second quarter position, which shows a net budget pressure of £4.8M, which is an improvement from the first quarter. Bournemouth, Christchurch, and Poole Council have not yet reported their second quarter position and had a forecast deficit of £7.6M in quarter one.

The system expects to achieve £16.3M Elective Recovery Fund income in the second half of 2021/22, matched by expenditure of the same amount, in addition to the first half of 2021/22 achievement. If the levels of income earned are not as planned there is a risk that the expenditure will have been committed and therefore not fully offset by income, leaving a cost pressure.

The NHS system delivered £5.0M efficiency savings in the first half of 2021/22 but to achieve a balanced financial position for the second half of the year requires delivery of £29.8m. This increase is reflective of the increased national expectation on all systems, including a greater level of savings required for those that had a deficit position pre-COVID.

NHS system CDEL envelope will be met this financial year, with an underspend in other capital funding arising in Dorset Healthcare and University Hospitals Dorset.

Although the system has achieved a breakeven plan for 2021/22 there remains a significant underlying deficit. After adjusting for non-recurrent income and expenditure and reflecting the actual run rates in organisations the current position is that NHS organisations have a total deficit of £139.3M in the underlying position.

Meeting Title:	**Board of Directors – Part 1**
Date of Meeting:	**26th January 2022**
Document Title:	**NED Champion Roles**
Responsible Director:	**Mark Addison, Trust Chair**
Author:	**Trevor Hughes, Head of Corporate Governance**

Confidentiality:	Not Confidential
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Non-Executive Director Meeting	7th January 2022	To inform the Board of Directors of the retained Board Champion roles, the identified NED Champions and responsibilities of previous Champion roles to be remitted to committees.

Purpose of the Paper	This paper advises the Board of the outcome of a national review undertaken by NHS England / Improvement during 2021 that reviewed the various Non-Executive Director (NED) Champion roles that had been developed in response to high profile failings in care or leadership. The paper identifies those NED champion roles that should be retained by the Board and outlines the responsibilities of previous NED champion roles that could be remitted to and discharged by Board committees.						
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	The Trust was approached by NHS England / Improvement (NHSE/I) in 2021 and actively participated in their national review of Non-Executive Director (NED) Board Champions roles. These roles had been developed as a result of high-profile failures in care or leadership nationally (e.g. Morecombe Bay, Mid Staffordshire Inquiries) in order to enhance board oversight of specific issues over a period of some years. The number of NED Champion roles was extensive and the legal basis for them varied from being a statutory requirement, to being suggested to improve Board oversight as part a report recommendation. The continuing requirement for NED Champion roles had also not been reviewed previously. NED roles required by the Constitution (i.e. that of the Senior Independent Director (SID)) did not form part of the national review. In December 2021, NHSE/I published the guidance *'Enhancing Board Oversight - A new approach to Non-Executive Director champion roles.'* This guidance outlines proposals for trusts to consolidate the number of formal NED Champion roles, providing roles descriptions or additional supporting information for these (see Appendix 1) and makes suggestions as to the most appropriate Board committee to discharge the responsibilities of other previous NED Champion roles. The December 2021 guidance proposes that trusts retain the following NED Champion roles and the following NED Champions were agreed: • Maternity Safety Board Champion – Sue Atkinson • Wellbeing Guardian – To be confirmed • Freedom to Speak Up NED Champion – Dave Underwood						

	• Doctors' Disciplinary NED Champion (Statutory requirement) – Ad hoc appointments on a case by case basis. • Security Management NED Champion – Stephen Tilton Further, the guidance proposes that the following responsibilities be remitted to and discharged by the following committees: Quality Committee • Hip fractures, falls and dementia • Palliative and end of life care • Resuscitation • Learning from deaths • Health and safety • Safeguarding • Safety and risk • Lead for children and young people Audit and Risk Committee • Counter fraud • Emergency Preparedness Finance and Performance Committee • Procurement • Cybersecurity People and Culture Committee • Security management – violence and aggression The Trust is about to commence annual reviews of committee effectiveness in order to inform possible amendments to committee Terms of Reference and Work Programmes. It is proposed that NHSE/I proposals for remitting NED Champion responsibilities be incorporated into respective committee Terms of Reference and Work Programmes as part of this review.
Action recommended	The Board of Directors is asked to: 1. **NOTE** the NHSE/I guidance on NED Champion roles and the identified DCH NED Champions identified for the retained roles 2. **APPROVE** the next steps to incorporate remitted NED Champion responsibilities within respective committee Terms of Reference and Work Programmes as part of the annual review of committee effectiveness process.

Governance and Compliance Obligations

Legal / Regulatory	N	Implementation of the NHSE/I guidance is not mandated but the guidance has been published following extensive national consultation and engagement and aims to enhance board oversight
Financial	N	
Impacts Strategic Objectives?	N	
Risk?	N	
Decision to be made?	Y	To approve the recommendation
Impacts CQC	Y	Implementation of the guidance will support committee effectiveness,

Standards?		enhance Board oversight and contribute to ensuring the Trust is Well Led.
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Classification: Official

Publication approval reference: PAR994

Enhancing board oversight

A new approach to non-executive director champion roles

Version 1, December 2021

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1. Summary

1.1 Introduction

This guidance sets out a new approach to ensuring board oversight of important issues by discharging the activities and responsibilities previously held by some non-executive director (NED) champion roles, through committee structures. It also describes which roles should be retained and provides further sources of information on each issue. For the purposes of this guidance the term NED champion includes ‘named NEDs’ and ‘NED leads’.

There are a range of issues which at various times have required additional board level focus to respond to and learn from high-profile failings in care or leadership. This has resulted in several reviews and reports establishing a requirement for trust boards to designate NED champions for specific issues to deliver change. This has led to an increasing number of roles spanning quality, finance and workforce.

The number of NED champion roles started to make it difficult for trusts to discharge them all effectively, particularly with a limited number of NEDs, and many do not have a role description, making it difficult to measure their impact on delivering change. Some roles have also been in place for over a decade without review.

Working with stakeholders, we have reviewed the issues the roles were originally established to address, to consider the most effective means of making progress now. There are a small number that are statutory requirements and some that still require an individual to drive change or fulfil a functional role. In these instances, the principle of the unitary trust board – with joint responsibility and decision making – remains. However, there are many issues where we now consider progress will be best made through existing trust committees rather than through individual NED champion roles.

This new approach will help enhance board oversight for these issues, by ensuring they are embedded in governance arrangements and assurance process, and through providing an audit trail of discussions and actions identified by committees. The risk of false assurance among chairs and directors who are not designated ‘champions’ will also be reduced, as oversight of transformational change to

improve care and responsibility to constructively challenge on all issues using Appreciative Inquiry approaches, will rest with the whole committee and not just an individual. By reducing the risk of individual NEDs becoming too involved in operational detail, this approach may also help maintain their independence – something that NEDs are uniquely positioned to bring to a board.

1.2 Status of guidance

This new approach is recommended but not mandatory. If trusts consider NED champion roles an effective tool to provide assurance to their board on specific issues, then they have the flexibility to retain or implement that approach.

1.3 Co-developing the approach

The new approach has been co-developed with a working group of trust chairs and we have also held a series of workshops with a range of providers. This enabled us to identify current roles and test alternative approaches to enhancing board oversight of important issues. We have engaged with national policy teams on the issues requiring oversight at board level that have associated NED champion roles. Further detail on each issue is provided in annexes 1 and 2.

We have engaged with the Care Quality Commission (CQC) throughout the development of this approach. While there is a shared understanding that strong leadership and board oversight is critical for the provision of high-quality care, the governance arrangements that individual trusts use to achieve this is expected to vary according to local circumstances and priorities. CQC inspectors will be looking for evidence of strong leadership and governance, with effective oversight of important issues. Trusts will be expected to demonstrate how they provide this, including with reference to this guidance where appropriate.

1.4 New recommended approach

For each issue, we identified the original review or report that recommended the establishment of a NED champion role and worked with the relevant national policy team to consider the current status of the role and the best way of responding to the issue at this point in time. In many cases, it was agreed that board oversight would be enhanced through a change from NED champion roles to committee discharge. It was also noted that the new approach should sit alongside other effective governance tools such as walkarounds, for example.

The table below sets out the NED champion roles that were in scope for this review and their status under the new approach.

Roles to be retained				
Maternity board safety champion	Wellbeing guardian	Freedom to speak up	Doctors disciplinary	Security management
Roles to transition to new approach				
Hip fracture, falls and dementia	Learning from deaths	Safety and risk	Palliative and end of life care	Health and safety
Children and young people	Resuscitation	Cybersecurity	Emergency preparedness	Safeguarding
Counter fraud	Procurement	Security management- violence and aggression		

It should be noted that the table above includes those issues for which a report or review has suggested a NED champion role should be established and does not include all important issues that trusts should have oversight of.

2. Implementation and support

To support the effective implementation of this new approach we recommend that trusts take the following steps:

2.1 Review current roles

Trusts should undertake a review to identify a list of their current NED champion roles. Annex 1 outlines roles that are statutory roles or that continue to require an individual to discharge those responsibilities. These roles should be retained. All other roles should be embedded in governance arrangements and aligned to committee structures where possible.

2.2 Align remaining roles to committee structures

Where we have recommended that issues are now discharged through a committee, we have grouped these issues by 'theme' to align with committee structures commonly used by trusts. However, this is not prescriptive, and trusts will want to align issues with the committee that they believe is the best fit and is aligned with their current governance arrangements.

Understandably some complex issues may fall under the remit of more than one committee structure – in these cases trust boards may wish to adopt a joint approach to ensure appropriate assurance.

2.3 Outline reporting structures

It will be up to trusts to decide how committees should report back on their assurance activities to the board, whether that is through existing reporting mechanisms or by establishing new periodic updates on issues that were previously the responsibility of a NED champion. Company secretaries may wish to ensure these issues are included on board/committee forward plans.

2.4 Update terms of reference

As trusts review their governance arrangements, they will want to ensure that committee terms of reference reflect any new responsibilities and respective reporting requirements because of these changes. Committee chairs and members

may wish to consider actions needed to discharge the roles effectively, such as regular engagement with an executive lead, background reading, visiting services and attending seminars or training as available and appropriate to the trust.

2.5 Ongoing support

While some trusts may already be working with similar arrangements, it is recognised that effective implementation may require cultural and behavioural shifts. To support implementation, it would be useful to receive trusts' feedback on where the proposed approach has worked well, to identify examples of best practice. We (NHS England and NHS Improvement) can then support in disseminating successful case studies and lessons learned with other trusts.

Existing platforms such as the NHS Providers Company Secretaries Network, existing care groups and regional forums will be used to share those learnings and collect feedback.

This guidance will be kept under review and updated as necessary.

Please send feedback and best practice examples to nhsi.providerpolicyengagement@nhs.net.

Annex 1: Retained NED champion roles

We have identified five NED champion roles which at this point should be retained. These are maternity board safety champion, wellbeing guardian, freedom to speak up guardian (FTSU), doctors disciplinary and security management. These should be retained because they are either a statutory requirement, the function requires a named individual to discharge or because we consider having an individual NED to be the most effective way of delivering the changes that are needed. This section provides further detail on these roles and additional sources of information are set out in the Resources section.

1. Maternity board safety champion

Applies to	All trusts providing maternity services
Type of role	Assurance
Legal basis	Recommended
Role description	Maternity NED role descriptor

In response to the Morecambe Bay Investigation (2015), this role was established through Safer Maternity Care 2016, which stated that “Senior trust managers will want to ensure unfettered communication from ‘floor-to-board’ by appointing a board level maternity champion”. The role is in line with recommendations from the Ockenden Review (2020) and while not a statutory requirement, for trusts providing maternity services having a named NED maternity board safety champion is recommended.

The champion should act as a conduit between staff, frontline safety champions (obstetric, midwifery and neonatal), service users, local maternity system (LMS) leads, the regional chief midwife and lead obstetrician and the trust board to understand, communicate and champion learning, challenges and successes.

The named champion could be the chair of the quality and safety committee and the requirements of the role could be discharged through the appropriate committee provided trusts ensure that the clinical director and director of midwifery are integral

to these committee meetings. NEDs should use appreciative inquiry approaches and the Maternity Self-Assessment Tool to provide assurance to the board that the best quality maternity care is being provided by their trust. Trusts may also wish to note that the NSR maternity incentive scheme safety actions refer to the maternity board safety champion role under Safety Action 9.

Along with other recommendations contained in the Ockenden Review, this role will be reviewed nationally in 2-3 years' time to gauge its effectiveness.

2. Wellbeing guardian

Applies to	All trusts
Type of role	Assurance
Legal basis	Recommended
Role description	Guardian community website and role description

This role originated as an overarching recommendation from the Health Education England 'Pearson Report' (NHS Staff and Learners' Mental Wellbeing Commission 2019) and was adopted in policy through the 'We are the NHS People Plan for 2020-21 – action for us all'. The NED should challenge their trust to adopt a compassionate approach that prioritises the health and wellbeing of its staff and considers this in every decision.

The role should help embed a more preventative approach, which tackles inequalities. As this becomes routine practice for the board, the requirement for the wellbeing guardian to fulfil this role is expected to reduce over time. The Guardian community website provides an overview of the role and a range of supporting materials.

3. FTSU NED champion

Applies to	All trusts
Type of role	Functional
Legal basis	Recommended
Role description	FTSU supplementary information

The Robert Francis Freedom to Speak Up Report (2015) sought to develop a more supportive and transparent environment where staff are encouraged to speak up about patient care and safety issues. In line with the review, it is recommended that all NHS trusts should have this functional FTSU guardian role so that staff have a clear pathway and an independent and impartial point of contact to raise their concerns in the organisation.

The role of the NED champion is separate from that of the guardian. The NED champion should support the guardian by acting as an independent voice and board level champion for those who raise concerns. The NED should work closely with the FTSU guardian and, like them, could act as a conduit through which information is shared between staff and the board (p.146, Francis FTSU report).

All NEDs should be expected to provide challenge alongside the FTSU guardian to the executive team on areas specific to raising concerns and the culture in the organisation. When an issue is raised that is not being addressed, they should ask why. A full description of NED responsibilities can be found in the FTSU supplementary information.

4. Doctors disciplinary NED champion/independent member

Applies to	All trusts (advisory for foundation trusts)
Type of role	Functional
Legal basis	Statutory
Role description	None

Under the 2003 Maintaining High Professional Standards in the modern NHS: A Framework for the Initial Handling of Concerns about Doctors and Dentists in the NHS and the associated Directions on Disciplinary Procedures 2005 there is a requirement for chairs to designate a NED member as “the designated member” to oversee each case to ensure momentum is maintained. There is no specific requirement that this is the same NED for each case. The framework was issued to NHS foundation trusts as advice only.

5. Security management NED champion

Applies to	All trusts, excluding NHS foundation trusts
Type of role	Assurance
Legal basis	Statutory
Role description	None

Under the Directions to NHS Bodies on Security Management Measures 2004 there is a statutory requirement for NHS bodies to designate a NED or non-officer member to promote security management work at board level. Security management covers a wide remit including counter fraud, violence and aggression and also security management of assets and estates. Strategic oversight of counter fraud now rests with the Counter Fraud Authority and violence/aggression is overseen by NHS England and NHS Improvement.

While promotion of security management in its broadest sense should be discharged through the designated NED, relevant committees may wish to oversee specific functions related to counter fraud and violence/aggression. We have included further guidance on these two functions in Annex 2. Boards should make their own local arrangements for the strategic oversight of security of assets and estates.

Annex 2: Issues that can be overseen through committee structures

This section covers those issues which reports or reviews previously suggested should be overseen by a NED champion, but which we now consider are best overseen through committee structures. Trusts should use their discretion to determine the relevance of each issue to their trust. It should be noted that there will be many other important issues not included in this guidance that trusts should also have oversight of.

For the purposes of this guidance the issues are grouped into 'themes' aligned to committee structures commonly used by trusts. However, each trust will need to determine whether each issue is relevant to their trust and how best they should be allocated to their committee structures, especially since some issues will cut across several committees. These issues and themes are summarised in table format under the resources section.

Quality and Safety Committee

1. Hip fractures, falls and dementia

All trusts and health boards should have a director with responsibility for falls and the 'National Audit of Inpatient Falls Audit (NAIF) Report 2020' recommends a patient safety group which is overseen by a member of the executive and non-executive team. This could be fulfilled by an executive rather than a NED, provided there is committee and board oversight of safety, prevention and risk management and use of data to gauge the effectiveness of practice.

Hip fractures and other serious harms resulting from inpatient falls can be linked to dementia. The board should consider the benefits of joint oversight and strategic planning across both agendas and implement where appropriate. Sufficient senior level support to enable systemic change is needed, including effecting change in partner external organisations and allocating resources as needed.

The Quality Committee may wish to ensure that the executive lead for dementia attends the Quality Committee and, in acute trusts, that they also attend the Dementia Steering Group, reporting issues into the Quality Committee. The NAIF audit has produced a useful information guide for healthcare champions which could be accessed to support this work.

2. Palliative and end of life care

The Ambitions for Palliative and End of Life Care National Framework 2021-26 set out six key ambitions for the improvement of Palliative and End of Life Care (PEoLC). Improving quality is one of the three strategic priorities of the national NHS England and NHS Improvement PEoLC programme, including high quality PEoLC, for all, irrespective of condition or diagnosis.

The impact of executive leadership on improving the quality of PEoLC is a theme that has been identified by the NHSE PEoLC team during visits to trusts. Having a NED as part of the PEoLC Executive committee, led to significant support at the Board and a focus on PEoLC. Board level oversight for PEoLC can be well supported through the Quality Committee, with reporting into the Board. The work of the Quality Committee might include:

- attendance of a NED from the Quality Committee at the PEoLC Executive Committee
- ensuring the board is aware of standards of care in PEoLC
- reviving PEoLC complaints to see where improvements could be made.

3. Resuscitation

Health Service Circular Series Number: HSC 2000/028 (Sept 2000) stipulates that chief executives of all NHS trusts should give a NED designated responsibility on behalf of the trust board for ensuring that a resuscitation policy is agreed, implemented, and regularly reviewed within the clinical governance framework.

This has been referred to more recently in the May 2020 Resuscitation Council Quality Standards in relation to acute, mental health and community trusts. The Quality Committee may wish to discharge this role, rather than an individual NED, and include this on the committee workplan, ensuring sign-off from the board.

4. Learning from deaths

Executive and non-executive directors have a key role in ensuring their provider is learning from issues such as incidents and complaints and identifying opportunities for improvement in healthcare identified through reviewing or investigating deaths. All NEDs play a crucial role in constructively challenging the executives to satisfy themselves that clinical quality controls and risk management systems are robust and defensible.

In particular, they should familiarise themselves with the care provided to individuals with learning disabilities and those with mental health needs and should encourage meaningful engagement with bereaved families/carers. The Quality Committee in particular should understand the Learning from Deaths review process, champion quality improvement that leads to actions that improve patient safety, and assure published information on the organisation's approach, achievements and challenges. Implementing the Learning from Deaths Framework: Key requirements for trust boards includes some useful questions that NEDs may wish to ask in relation to these responsibilities.

5. Health and safety

Strong leadership at board level and a strong safety culture, combined with NED scrutiny, are essential. Health and safety should be viewed in its broadest sense to include patient safety, employee safety, public safety and system leadership. As such the remit will cut across committees including Quality, Workforce/People and Planning (estates). All committees need to help ensure their organisation gets the right direction and leadership on health and safety matters through performing a scrutinising role – ensuring the integrity of processes to support boards facing significant health and safety risks.

Committee members should have a sound understanding of the risks, the systems in place for managing them, an appreciation of the causes of any failures and an understanding of the legal responsibilities of employers and individual directors for ensuring the health and safety of workers and others affected by work activities. They should be familiar with the trust's health and safety policy – which should be an integral part of the organisation's culture, values and standards – and assure themselves that this is being followed.

6. Safeguarding

Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff suggests that boards should consider the appointment of a NED to ensure the organisation discharges its safeguarding responsibilities appropriately and to act as a champion for children and young people.

This role could be discharged through a committee but in ensuring appropriate scrutiny of their trust's safeguarding performance, all board members should have Level 1 core competencies in safeguarding and must know the common presenting features of abuse and neglect and the context in which it presents to healthcare staff. In addition, board members should understand the statutory role of the board in safeguarding including partnership arrangements, policies, risks and performance indicators; staff roles and responsibilities in safeguarding; and the expectations of regulatory bodies in safeguarding.

The CQC Trust-Level Well Led Framework does not reference a safeguarding NED; rather it notes that the inspection team should speak to the/any senior member of the organisation with safeguarding responsibility.

7. Safety and risk

The Trust-Level Well-Led Inspection Framework refers to interviewing a sample of NEDs with the NED for safety and risk being a priority. This is not intended to imply that a specific NED champion role should be in place. Moreover, it refers generally to a NED that would have suitable oversight of these areas such as the chair of Quality and/or Audit committees as examples.

CQC have endorsed the new approach recommended in this guidance. However, should trusts wish to do so, then allocating the role to an individual NED as one tool for ensuring strong leadership and governance is acceptable practice.

8. Lead for children and young people

The Core Service Inspection Framework for Children and Young People (CYP) refers to an interview with the 'NED on the board with responsibility for CYP'. This is not intended to imply that a specific NED lead role should be in place. Moreover, it refers generally to a NED that would have suitable oversight of this area, such as the chair of quality for example. CQC have endorsed the new approach recommended in this guidance. However, should trusts wish to do so, then

allocating the role to an individual NED as one tool for ensuring strong leadership and governance is acceptable practice.

Audit and Risk Committee

9. Counter fraud

The role of fraud champion is one that is suited to a senior manager who is directly employed by the trust. This could also be an executive but is not intended to be a NED role. The 2004 Counter Fraud Directions included a requirement for NHS trusts to designate a NED to undertake specific responsibility for counter fraud. However, these were revoked by the 2017 Directions on Counter Fraud, so there is no longer a statutory requirement to designate a NED champion for counter fraud.

NHS funded services are required to provide the NHS Counter Fraud Authority (NHSCFA) details of their performance annually against the Government Functional Standard 013: Counter Fraud and NHSCFA ask that the audit committee chair (usually a NED) signs off the trust's submissions. The audit committee chair (and members) may also wish to review the local counter fraud specialist's (LCFS) final reports and consider any necessary improvements to controls, along with any recommendations contained within reports following NHSCFA's engagement through its quality assurance programme.

10. Emergency preparedness

The NHSE Emergency Preparedness, Resilience and Response (EPRR) Framework sets out the responsibilities of the accountable emergency officer (AEO), who is expected to be a board level director with executive authority and responsibility for ensuring that the organisation complies with legal and policy requirements.

The Framework suggests that a NED or other appropriate board member should support the AEO and endorse assurance to the board that the organisation is complying with legal and policy requirements. This will include assurance that the organisation has allocated sufficient experienced and qualified resource to EPRR.

The independence that NEDs bring is essential to being able to hold the AEO to account, but responsibility for EPRR sits with the whole board and all NEDs should assure themselves that requirements are being met. EPRR should be included on

appropriate committee forward plans and EPRR board reports, including EPRR annual assurance, should be taken to the board at least annually.

Given the synergies between the agenda for EPRR and other important issues such as security management and health and safety, triangulation between these areas through the Board and committees will be essential.

Finance, Performance and Planning Committee

11. Procurement

Procurement should be seen by the board as a value-adding function. The Finance, Performance and Planning Committee should help raise awareness of commercial matters at board and director levels and facilitate discussions that identify benefits to procurement activity and strategic development. The committee would need to understand the scope of procurement, the priorities (at national and at integrated care system level) and the challenges of delivering change. The Audit Committee should regularly review procurement.

Our Procurement Target Operating Model (PTOM) programme team is seeking ambassadors who can advocate and raise the profile of procurement at a local level. This role can also be carried out by an executive, provided there is committee and board oversight. NEDs should collectively provide assurance via these committees to the board that their trust is viewing procurement as a priority, engaging with the PTOM programme and aligning their procurement activity with national activity.

12. Cyber security

Board leadership is seen as essential to the success of this agenda so trusts may decide it is more appropriate for this function to be discharged by the board than a committee. NEDs should provide check and challenge, ensuring information governance has been considered in all decisions and that this can be evidenced.

Each trust should have a senior information risk owner (SIRO), who would usually be an executive, although trusts can appoint a NED to this role should they wish to do so. The SIRO should ensure on behalf of the board that the 10 minimum cyber-security standards are followed throughout their organisation.

The board/committee should regularly review cyber security risks, ensuring appropriate mitigation, and that regular maintenance of critical systems and equipment takes place, while minimising impact on clinical services during system downtime. This should include the following:

- Removal of unsupported systems from trust networks.
- Timely patching of systems and prompt action on high severity Alerts when they are issued.
- Ensuring robust and immutable backups are in place.

It is also recommended that boards undertake annual cyber awareness training, in addition to the mandatory and statutory information governance training that individual board members are required to complete.

Workforce/People Committee

13. Security management – violence and aggression

As set out in 'We are the NHS People Plan for 2020-21 – action for us all' and the NHS Violence Prevention and Reduction Standard 2020, the board may wish to ensure the following:

- The trust has committed to develop a violence prevention and reduction strategy and this commitment has been endorsed by the board, which is underpinned by relevant legislation (set out in the Violence Prevention and Reduction Standard 2020), ensuring the strategy is monitored and reviewed regularly – 'regularly' to be decided by the board.

- Inequality and disparity in the experience of any staff groups, including those with protected characteristics, has been addressed and clearly referenced in an equality impact assessment, which has been made available to all stakeholders.

- A senior management review is undertaken twice a year and as required or requested, to evaluate and assess the Violence Prevention and Reduction Programme, the findings of which are shared with the board.

The Workforce/People Committee may wish to align this with wider wellbeing work being undertaken by the committee, particularly in relation to wellbeing support after violence.

Resources

Summary of roles by suggested committee and further sources of information

The following is a list of further reading that NEDs and other board members may find useful in developing their knowledge and understanding of the issues highlighted in this document.

Role	Links to further reading
General	
Maternity board safety	• Morecambe Bay Investigation (2015) • Ockenden Review (2020) • NSR Maternity Incentive Scheme Safety Actions • Maternity and Neonatal Safety Champions Toolkit • Transforming Perinatal Safety Resource Pack • NHS England and NHS Improvement Maternity Safety Resources • Safer Maternity Care 2016
Wellbeing guardian	• Guardian Community website and role description • Health Education England 'Pearson Report' (NHS Staff and Learners' Mental Wellbeing Commission 2019)
Freedom to speak up	• Report template – NHS England and NHS Improvement website (england.nhs.uk) • Robert Francis Freedom to Speak Up report • FTSU supplementary information • FTSU Guidance and self-review tool
Doctors disciplinary	• Directions on Disciplinary Procedures 2005 • Maintaining High Professional Standards in the modern NHS
Security management	• Directions to NHS Bodies on Security Management Measures 2004

Role	Links to further reading
Quality and Safety Committee	
Hip fracture, falls and dementia	• Patient Information Resource National Audit of Inpatient Falls- Guide for Healthcare Champions • National Audit of Inpatient Falls (NAIF) 2020 Annual Report | RCP London • NICE Guidance - Falls in Older People: Assessing Risk and Prevention • Dementia Care Pathway- Full implementation guidance • Dementia wellbeing in the COVID pandemic • NHS England Dementia: Good Personalised Care and Support Planning Information for primary care providers and commissioners - Guidance
Palliative and end of life care	• Ambitions for Palliative and End of Life Care: a national framework for local action 2021-2026 • "What NHS England is doing to improve end of life care", NHS England and NHS Improvement webpage • "Resources on End of Life Care", NHS England and NHS Improvement webpage
Resuscitation	• Quality Standards: Acute Care, Resuscitation Council UK
Learning from deaths	• https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf
Safety and risk	• Inspection Framework – trust-wide well led, CQC
Lead for children and young people	• Inspection framework – NHS Hospitals services for children and young people, CQC
Safeguarding	• Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff
Health and safety	• "Leading Health and Safety at Work", HSE webpage • FAQs: Leading health and safety at work, HSE webpage • Leading health and safety at work: Actions for directors, board members, business owners and organisations of all sizes- Guidance, HSE

Role	Links to further reading
Audit and Risk Committee	
Counter fraud	• Refer to service condition 24 of the NHS standard contract: 2021/22 NHS Standard Contract, NHS England and NHS Improvement • "Information for Fraud Champions", Fraud Prevention, NHS Counter Fraud Authority webpage
Emergency preparedness	• NHS England and NHS Improvement Emergency Preparedness, Resilience and Response Framework – Guidance
Finance, Performance and Planning Committee	
Procurement	• NHS Procurement: Raising Our Game – Best Practice Guidance
Cyber security	• 2017/18 Data Security and Protection Requirements- Guidance • Data Security and Protection Toolkit, NHS Digital • The Minimum Cyber Security Standard- Guidance, Cabinet Office • Lessons learned review of the WannaCry Ransomware Cyber Attack – Independent report
Workforce/People Committee	
Security management - violence and aggression	• Violence prevention and reduction standard

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This publication can be made available in a number of other formats on request.

Meeting Title:	DCHFT Board
Date of Meeting:	26th January 2022
Document Title:	**DCH Charity – Finance report (Q3)**
Responsible Director:	Nicholas Johnson, Deputy Chief Executive
Author:	Simon Pearson, Head of Charity & Social Value James Claypole, DCH Deputy Financial Controller

Confidentiality:	
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
DCH Charity Finance meeting	13.1.22	Monthly finance review (Head of Charity/Dep Financial Controller)

Purpose of the Paper	To report DCH Charity's financial position (Q3 21/22) in light of the impact of the Covid pandemic on charitable income.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	The enclosed report presents DCH Charity's current financial position (Q3 21/22) and year-end forecast. Key information: • Opening balances • Incoming resources • Expenditure • Reserves • Year-end forecast							
Action recommended	The Trust Board is recommended to: 1. **NOTE** DCH Charity's current financial position and year end forecast 2021/22							

Governance and Compliance Obligations

Legal / Regulatory	Y	Charities Act (2011)
Financial	N	
Impacts Strategic Objectives?	N	
Risk?	N	
Decision to be made?	N	
Impacts CQC Standards?	N	
Impacts Social Value ambitions?	Y	DCH Charity contributes to DCHFT's social value commitments as an anchor institution.
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

DCH Charitable Fund – Finance Report (December 2021 (M9))

The Covid-19 pandemic has continued to impact on charitable income during 2021-22. The DCH Charity Business Plan 2021/22 has focused on maintaining the charity's financial sustainability, whilst planning to grow its income as the UK economy recovers during the strategic period to 2025/26.

Overview
The Charitable Funds closing balance as at 31st December 2021 was **£1,459,728.71**.

Opening Balances
The Charitable Funds Opening balance at 1st April 2021 was **£1,410,890.92**

Incoming Resources
Incoming resources totalled **£353,734.10** this is broken down into:

- Donations total **£52,738.04** and includes £16,429.52 received in donations for the Chemo Unit Appeal, £7,611.16 for Cancer Services, £7,276.07 General Purpose, £3,562.41 for SCBU and £3,143.55 for Critical Care.

- Legacies received total **£75,366.09** and relates to a legacy received for the Renal Unit of £6,057.70. A legacy for the General Purpose Fund of £69,308.39 has been accrued based on the final distribution estimate from solicitors and the income was received in November 2021. A legacy is also expected for Kingfisher Fund.

- Grants total **£173,972.66** and includes the following received this year:
  - £46,342.37 received from Rotary towards the Chemo Unit Refurbishment patient chairs.
  - £14,643 from NHS Charities Together for an Operational Support Grant for the Charity in relation to its work on the NHSCT Community Partners grant bid for Dorset.
  - £70,000 from Fortuneswell Cancer Trust for the EBUS Additional Scope,
  - £20,000 from the DCH Friends for purchase of Ultrasound Machine for Rheumatology, £10,000 was also received from The Stroke Club towards Stroke Services at DCH
  - £5,872.10 has been invoiced to Cancer Research UK for Cancer Services
  - £5,000 for the Bereavement Fund.

- Events total **£49,679.35** which relates to community fundraising events for SCBU, Chemo Appeal, Cancer Services, General Purpose Fund and for Family Services by our supporters. SCBU Sunflowers event saw £24,000 raised for the SCBU Unit.

Expenditure and Commitments
Expenditure and Commitments total **£304,896.31** and this is broken down into:

- Governance Charge full year commitment totals £162,688.11 and this includes the cost of the Fundraising Team (pay and non-pay elements), Audit Fees and the Bank Charges. This is allocated across the funds with:

- The Fundraising Team 2021/22 cost apportioned 25% across restricted fund balances and 75% across unrestricted fund balances.

- Audit Fee and Bank charges are apportioned on closing fund balance across all funds.

- There was the purchase of the EBUS Ultrasound additional scope £70,000 and the Ultrasound Machine for Rheumatology £20,000 and the VAB Biopsy Equipment £10,000

- Other Expenditure reflects the commitments made for COVID-19 to support staff welfare and other commitments made to support and enhance patient care at Dorset County Hospital.

Reserves Position
The reserves position at the end of December 2021, against the reserves target of **£200,000**, is a **surplus of £36,189.25**

The reserves should cover a rolling 12 month period and therefore these will need to cover the support & governance costs for the period April – December in financial year 2022/23.

Year-end Forecast
Due to the continuing impact of the pandemic on UK charitable income, DCH Charity's year-end income is currently re-forecast to achieve c.£585K (budget £675K). Known income is expected from further NHS Charities Together grants; a notified Legacy (for Kingfisher) and a significant contribution from DCH Pharmacy sub-co annual profits; in addition to ongoing receipt of donations and fundraising income. This would be an improved position on 2020/21 which achieved £500K income. Year-end forecasts and the Charity's Risk Register will be reviewed at the Charity's Q3 financial review (1.2.22) by the DCH Charity Strategy Group.

DCH Charity is currently finalising its Strategic Business Plan 2022-25 which will be submitted to DCHFT Board (as Corporate Trustee) in March 2022.

Simon Pearson
Head of Charity & Social Value

James Claypole
Deputy Financial Controller
14th January 2022

Meeting Title:	Board of Directors Part 1
Date of Meeting:	26th January 2022
Document Title:	**Board Assurance Framework**
Responsible Director:	Nick Johnson – Director of Strategy, Transformation & Partnerships. Deputy CEO.
Author:	Ciara Darley – Programme Manager, Transformation & Improvement

Confidentiality:	*Not Confidential*
Publishable under FOI?	*Yes/~~No~~*

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Executive Management Meeting	17th Dec 21	Risk calculation score to be checked
Trust Board	24th Nov 21	New BAF template approved with one amendment.
Risk and Audit Committee	16th Nov 21	Recommended to Board to approve new template.
Risk and Audit Committee	18th Jan 22	

Purpose of the Paper	To provide members of the Executive Management Team the opportunity to discuss and recommend any amendments to the Board Assurance Framework prior to bi-monthly submission to the Board.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	The Board needs to understand the Trust's strategic objectives and the principle risks that may threaten the achievement of these objectives. The Board Assurance Framework (BAF) provides a structure and process that enables the organisation to focus on those risks that might compromise achieving its most important strategic objectives; and to map out both the key controls that should be in place to manage those objectives and confirm the Board has assurance about the effectiveness of these controls. The Trust Strategy was updated in May 2021, with three new Strategic Themes – People, Place and Partnerships. Since its publication, a number of Strategic Objectives have been agreed and have been included within the revised BAF Template, which was approved at Trust Board in November 2021. The principle risks to achieving these strategic objectives have been identified and scored using the Trusts risk scoring matrix. The summary position highlights the Strategic Theme of Place to contain the most risks in particular, Objective 1: We will deliver safe, effective and high-quality personalised care for every patient focussing on what matters to every individual. All Executives were asked to review and provide updates where appropriate to the relevant BAF items. Changes have been summarised below: **Strategic Theme:** Place **Strategic Objective 1**: We will deliver safe, effective and high-quality personalised care for every patient focussing on what matters to every individual **Risk Reference:** PL 1.3 **Risk description:** If we continue to not achieve the national performance standards due to long waiting times then we will not provide high quality care in ways that matter for our patients so the clinical strategy will not be delivered and							

	therefore the objective of high-quality care that is safe and effective will not be met. • Likelihood score moved from a 4 to a 5, meaning that the Risk score has increased from 16 to 20. New national guidance is due which details a multiyear approach to regaining access standards which may further alter this input within the BAF. **Risk Reference:** PL1.7 **Risk description:** Having No Reason to Reside patients pathways 1-3 for periods greater than 1 day • Risk embedded within PL1.6 If we fail to work with our partners on effective criteria to admit, criteria to reside, and discharge pathways, then patients will have unnecessary and lengthy hospital stays leading to poorer outcomes and therefore the objective of high care that is safe and effective will not be met. Similarly, the above concern would mean we are not contributing to a strong, effective Integrated Care System, focussed on meeting the needs of the population **Risk Reference:** PL1.8 **Risk description:** Not achieving an integrated community health care hub based on the DCH site • Risk removed as no longer a strategic risk **Strategic Theme:** Place **Strategic Objective 2**: We will build sustainable infrastructure to meet the changing needs of the population **Risk Reference:** PL2.1 **Risk Description:** If we do not commit sufficient resources to New Hospital Project and wider strategic estates development then plans and business cases will not be robust so we will not receive funding to deliver • Likelihood score changed from a 3 to 4 meaning that the risk score is now 20 (extreme risk) **Strategic Theme:** Place **Strategic Objective 3**: We will utilise digital technology to better integrate with our partners and meet the needs of patients **Risk Reference:** PL3.2 **Risk Description:** Not providing adequate cyber security defences to protect the Trust's digital assets • New risk added – risk score: 12 **Risk Reference:** PL3.3 **Risk Description:** Trust staff not trained sufficiently to minimise targeted and social engineering threat attempts • New risk added – risk score: 12 In addition to the above, the Risk Owner section has been updated for the following risks: PL 1.1, 1.2, 4.1, 4.2
Action recommended	The Board is requested to: • Review the Board Assurance Framework; and • Note the high-risk areas

Governance and Compliance Obligations

Legal / Regulatory	Y/~~N~~	
Financial	~~Y~~/N	The Board Assurance Framework includes risks to long term financial

		stability and the controls and mitigations the Trust has in place.
Impacts Strategic Objectives?	Y/~~N~~	The Board Assurance Framework outlines the identified risks to the achievement of the Trust's objectives. Failure to identity and control these risks could lead to the Trust failing to meet its strategic objectives.
Risk?	Y/~~N~~	The Board Assurance Framework highlights that risks have been identified and captured. The Document provides an outline of the work being undertaken to manage and mitigate each risk. Where there are governance implications to risks on the Board Assurance Framework these will be considered as part of the mitigating actions.
Decision to be made?	~~Y~~/N	
Impacts CQC Standards?	Y/~~N~~	It is a requirement to regularly identify, capture and monitor risks to the achievement of the Trusts strategic objectives.
Impacts Social Value ambitions?	~~Y~~/N	
Equality Impact Assessment?	~~Y~~/N	
Quality Impact Assessment?	~~Y~~/N	

BOARD ASSURANCE FRAMEWORK - SUMMARY
DATE: Jan-22

Summary Narrative

In total, the Board Assurance Framework includes 34 risks.

The most significant areas of risk that could prevent the Trust from achieving its strategic objectives fall within the PLACE theme. There are three high risks aligned to Objective 1: We will deliver safe, effective and high-quality personalised care for every patient focusing on what matters to every individual. These included the inability to recruit and retained sufficiently skilled clinical staff to meet demand, continuing to not achieve care standards, and emergency and urgent care pathways not meeting the increase in unplanned attendances.

In addition, there is a high risk to achieving the second PLACE objective to build sustainable infrastructure to meet the changing needs of the population. The risk recognises the need to commit sufficient resources to New Hospital Project and wider strategic estates development then plans.

Within the PEOPLE theme, there is a high risk associated with Objective 1 - We will look after and invest in staff, developing our workforce, creating collaborative and multidisciplinary teams to support outstanding care and equity of outcomes. The risk highlights that failure to attract and retain the right people with the right skills puts more pressure on existing teams.

Within PARTNERSHIP there is one high risk aligned to Objective 2 - We will ensure best value for the population in all that we do and we will create partnerships with commercial, voluntary and social enterprise organisations to address key challenges in innovative and cost-effective ways. The risk is of failure to deliver sustained financial breakeven and to be self sufficient in cash terms.

The current COVID-19 Pandemic is putting severe strain on the Trust in the short term which may have consequences for the longer term achievement of the Strategic Objectives. However, it is too early to determine this.

The spread of risk across the framework has been demonstrated within the Risk Heatmap.

Risk Heatmap

		LIKELIHOOD SCORE				
		1	2	3	4	5
CONSEQUENCE SCORE		Rare	Unlikely	Possible	Likely	Almost certain
5	Catastrophic	5	10	15 PL2.1 →	20 PE1.2, PL2.1	25
4	Major	4	8 PE3.1, PA1.1, PA3.1, PA3.2	12 PE2.1, PE3.3, PA2.2	16 PE1.1, PL1.2, PL1.10, PL2.2, PA3.3 PL1.3 →	20 PL1.1, PL1.5, PA2.1, PL1.3
3	Moderate	3	6 PE3.4, PL1.4, PA1.3, PA2.3	9 PA1.2, PA4.1	12 PE3.2, PL1.6, PL3.2, PL 3.3, PL4.1, PL4.2, PA1.4	15
2	Minor	2 PL1.9	4	6	8	10
1	Negligible	1	2	3	4	5

Key

Letters:	
PE	PEOPLE
PL	PLACE
PA	PARTNERSHIP
Numbers (example):	
1.1	Objective 1 , Risk 1
1.2	Objective 1, Risk 2
2.1	Objective 2, Risk 1

Risk Ref:	Responsible Director	Risk Description/Risk Owner:	Consequence Score	Likelihood Score	Risk Score	Existing Mitigation/ Controls	Strength of Control	Assurance/ Evidence	Strength of Assurance	Target Risk Score
People Objective 1 We will look after and invest in staff, developing our workforce, creating collaborative and multidisciplinary teams to support outstanding care and equity of outcomes										
PE 1.1	DH	**Risk description:** Failure to balance wellbeing needs of staff with service delivery and recovery **Risk owner:** CPO	4	4	16	• People strategy • People performance dashboard • People Committee reports • People recovery steering group • Targeted wellbeing support • Wellbeing offer • System & national wellbeing offers	Good	• People strategy (development) • People Dashboard - PCC • PCC reports • FPC reports • Divisional performance reviews • Quarterly people pulse survey • National staff survey • FTSUG reports • Staff listening exercises • Exit interviews	Good	12
PE 1.2	DH	**Risk description:** Failure to attract and retain the right people with the right skills puts more pressure on existing teams **Risk owner:** CPO	5	4	20	• People strategy development • Implementation of workforce business partner model • System attraction strategy • Resourcing function business case • Career pathways • CESR academy proposition • Locally employed doctor appraisal and development • Pilot site for national stay and thrive initiative & international nurse experience deep dive • OD team • Development of flexible & temporary staffing function • Inclusive leadership programme • Transforming people practices programme • Values based recruitment -HCA workforce	Good	• People strategy (development) • People Dashboard - PCC • PCC reports & workplan • Divisional performance reviews • Recruitment control panel • System workforce plan	Good	15
People Objective 2 We will create an environment where everyone feels they belong, they matter and their voice is heard										
PE 2.1	DH	**Risk description:** Not creating a culture and environment where ALL stay feel valued, heard and that they belong impacting attraction, availability and retention **Risk owner:**	4	3	12	• People strategy • EDI roadmap – culture transformation programme (inclusive leadership development, transforming people practices work streams) • Staff networks x 5 • FTSUG and champions • People performance dashboard as cultural barometer • Exit interviews	Good	• People performance Dashboard - PCC • PCC workplan • PCC deep dives • Divisional performance reviews • EDI steering group • Exec sponsors for staff networks • Quarterly pulse survey • National staff survey • Junior dr survey	Good	8
People Objective 3 We will improve safety and quality of care by creating a culture of openness, innovation and learning										
PE 3.1	DH/NL	**Risk description:** People not feeling safe to speak out about safety and care quality **Risk owner:** CPO/CNO	4	2	8	• Trust strategy • Trust values • People strategy • Implementation of just & learning culture principles • Raising concerns policy • Whistleblowing policy • Trust induction • Leadership & management development • FTSUG and champions • Safety walkabouts • Ward accreditation framework • Incident reporting	Good	• People performance Dashboard - PCC • PCC workplan - FTSU report, review of whistleblowing arrangements • Implementation of just & learning culture • Inpatient surveys • Datix	Good	4
PE 3.2	NJ	**Risk description:** Operational pressures will stifle will and capacity for innovation **Risk owner:**	3	4	12	• Quality Improvement and Innovation Programme overall supports importance and value of innovation and learning and provides resource support • QSIR Training protected and supported by division • Transformation and Improvement team providing support • Research and Innovation strategy and plan • Engagement in Academic Health Science Network • Divisional Performance Meetings with focus on innovation	Good	• S&T SLG reporting on QI programme and progress • Research and Innovation Governance • Divisional Performance Meetings	Good	6
PE 3.3	DH	**Risk description:** Operational pressures reduce capacity for learning **Risk owner:**	4	3	12	• People strategy • Appraisal policy • Medical appraisal • Study leave policy • Mandatory training KPI's • Practice education team • PCC reporting • Quality committee reporting • PCC and QC risk sharing & triangulation	Good	• Mandatory training KPI's • Appraisal KPI's • Monthly performance review • PCC reports • QC reports • Medical and nursing revalidation • System education workstreams	Good	8
PE 3.4	AH	**Risk description:** Not being an exemplar site for clinical research and innovation **Risk owner:** Medical Director	3	2	6	• Strong clinical research and innovation programme. • Research Strategy in place for 2019-22 with plans to review in 2022.	Good	• Reports to Quality Committee through the Urgent and Integrated Care division - with annual reporting to Board.	Good	6

Risk Ref:	Responsible Director	Risk Description/Risk Owner:	Consequence Score	Likelihood Score	Risk Score	Existing Mitigation/ Controls	Strength of Control	Assurance/ Evidence	Strength of Assurance	Target Risk Score
Place Objective 1: We will deliver safe, effective and high-quality personalised care for every patient focussing on what matters to every individual										
PL 1.1	NL	**Risk description:** Inability to recruit or retain sufficiently skilled clinical staff to meet the demand of patients then will not be able to meet care standards required so will not meet the strategic ambitions on quality, personalised care and financial objectives. **Risk owner:** Dawn Harvey (CPO): Recruitment & retention - People Strategy	4	5	20	See People objective • Recruitment and retention policies and work streams • International recruitment • Wellbeing support • Maximise use of opportunities through Health Education England and NHSE/I funding streams • Maximise where able apprenticeships • Workforce planning and innovation with redesign of roles to enable clinicians to practice at the top of their licence • Increased opportunities for supported training places Controls non-HR/OD: • Protocols and policies for clinical care • Quality improvement work to streamline care or improve effective patient care • Compliance with national standards to support patient care • Engagement with service users to assist in re-design effective and efficient care to maximise workforce efficiencies • Sub-board oversight of standards delivery and interventions as part of strategic objectives	Good	• Sub board reports: PCC; QC & RAC • Recruitment activity reports • Patient feedback • Staff feedback • Incident data • External assurance monitoring: CQC; CCG; auditors inc GIRFT/Networks • Corporate risk register actions and tolerated/managed risk	Strong	8
PL 1.2	NL	**Risk description:** If the population demand is over the ability to create and deliver capacity that meets the constitutional standards and quality standards outline under the CQC regulatory framework then the clinical strategy will not be delivered and therefore the objective of high-quality care that is safe and effective will not be met. **Risk owner:** Nicky Lucey (CNO) for quality & safety Alastair Hutchison - Clincial strategy including GIRFT & safety Paul Goddard - estates strategy	4	4	16	• Capacity planning • Commissioning of capacity • Clinical pathways design and system working for sustained capacity • Estates strategy • Workforce planning including job planning • Quality Improvement to redesign pathways to more efficient or productive with funded capacity • Access policies and processes to ensure effective waiting list management in order of clinical need with consideration for health inequalities • Recovery plan and oversight of the delivery through sub-board committee • ICS partnership working through provider collaboratives • ICS governance framework • Clinical networks to support pathway design and resources based on population need	Good	• Sub-board committee FPC, QC & PC • Estates master plan and assocaited business cases • Performance scorecard • External performance monitoring (CQC; OFRG; NHSE/I) • Benchmarking data: clinical networks; GIRFT	Strong	8
PL1.3	AT	**Risk description:** If we continue to not achieve the national performance standards due to long waiting times then we will not provide high quality care in ways that matter for our patients so the clinical strategy will not be delivered and therefore the objective of high-quality care that is safe and effective will not be met. **Risk owner:** Associate Director of Performance	4	5	20	• Quality improvement plans within Divisions and key work streams to support delivery of key KPIs supporting quality improvement • Elective Performance Management Group - workstreams aligned to operational planning guidance. Performance Framework - triggers for intervention/support • Provider assurance framework/Finance and Performance Committee	Good	• Division and work stream action plans. External contracting reporting to CCG. Divisional exceptions at Quality Committee • Performance monitoring via weekly PTL meetings, fortnightly EPMG and monthly Divisional Performance Meetings (through to Sub-Board and Board)	Good	12
PL 1.4	AT	**Risk Description:** If we don't have Emergency Preparedness and Resilience Plans then we will not have a defined programme to manage safe services and the triggers for altering those services under change services, therefore the objective of high-quality care that is safe and effective will not be met. **Risk owner:** Head of EPRR	3	2	6	• Emergency Preparedness and Resilience Review Committee (EPRR) reporting, EPRR Framework and review and sign off by CCG and NHSE	Good	• Reporting from EPRR Committee to Risk and Audit Committee and via assigned NED to Board. Yearly self assessment against EPRR core standards ratified by Local Health Resilience Partnership. Internal Audit reports	Good	6
PL 1.5	AT	**Risk description:** If our emergency and urgent care pathways do not meet the increase in unplanned attendances then patients will wait too long for appropriate care in emergency situations and therefore the objective of high-quality care that is safe and effective will not be met. Similarly the above concern would mean we are not contributing to a strong, effective Integrated Care System, focussed on meeting the needs of the population **Risk owner:** Chief Operating Officer	4	5	20	• Reframed Urgent and Emergency care Boards and ICPCS Boards objectives linked to the Boards delivery plan. CEO is the system SRO care and health inequalities. • Performance Framework reporting - triggers for intervention/support • Redesign through ED15 to increase estate and flow within current dept including committment to increased workforce • Increase to 7 day SDEC offer across medicien and surgical specialties • Clinical and People Strategies addressing emergency flow Home First Board work streams • Internal Home First work streams - 7 day discharge services, strengthened front door multi-agency response, PAT	Good	• Upward reporting and escalation from UECB to SLT and DCH Board. • Ward to Board reporting Home First Board and workstream documentation Home First (DCH) documentation Divisional reporting via Perfromance Meetings, FPC, Seasonal Surge Plan and reporting IMT Reporting ROI reporting against investment in ED15 model to UECB ED15 Steering Group through to FPC updates	Good	12
PL 1.6	AT	**Risk description:** If we fail to work with our partners on effective criteria to admit, criteria to reside, and discharge pathways, then patients will have unnecessary and lengthy hospital stays leading to poorer outcomes and therefore the objective of high care that is safe and effective will not be met. Similarly the above concern would mean we are not contributing to a strong, effective Integrated Care System, focussed on meeting the needs of the population **Risk owner:** Chief Operating Officer	3	4	12	• Home First Board membership • Urgent and Emergency Care Board - CEO is SRO and COO membership • Investments in ED capacity, SDEC 7-day working, 7-day discharge services, increased Acute Hospital at Home capacity • Home First (DCH) Steering Group - PAT, redesign of discharge support, CCTR, MDT working, strengthened front door multi-agency response. • VSCE support front door and discharge response Clinical and People Strategies for front door response • Redesign of patient flows through the hospital with particular focus on ambulatory pathways and proactive discharge management	Requires Improvement	Home First Board papers UECB papers Divisional reporting to FPC Performance Report - FPC ROI reporting to UECB on investments into patient flow schemes Home First (DCH) Steering group papers.	Requires Improvement	9
PL 1.9	AT	**Risk description:** If we do not provide as a minimum 35% of our outpatient activity away from the DCH site then we will not be delivering and designing care in a way which matters to patients or building on sustainable infrastructure and digital solutions to better meet the needs of our population. **Risk owner:** Chief Operating Officer	2	1	2	• Outpatient Improvements (within Elective Care Board Programme) Clinical and People Strategies (including physical capacity required)	Good	• Reports to SLG and through to Board via Strategy updates	Good	2
PL 1.10	AH	**Risk description:** Not maintaining the Trusts Summary Hospital-Level Mortality Indicator within the 'as expected' range. **Risk owner:** Chief Medical Officer	4	4	16	• Scrutinising other care quality indicators to assure standards of care • Ensuring accuracy and timeliness of clinical coding by reporting by exception to FPC	Requires Improvement	• Regular reports to Hospital Mortality group, Quality Committee and Board.	Good	8
Place Objective 2: We will build sustainable infrastructure to meet the changing needs of the population										
PL 2.1	NJ	**Risk description:** If we do not commit sufficient resources to New Hospital Project and wider strategic estates development then plans and business cases will not be robust so we will not receive funding to deliver **Risk owner:** Strategic Estates Project Director	5	4	20	• Full Programme Structure in place with dedicated team • NHP Project Board, Clinical Assurance Group, • Finance and Performance Committee into Trust Board - Lobbying of NHSEI/NHP team re. seed-funding at all levels	Good	• NHSEI SOC Approval; - NHSEI NHP Deep Dive re. OBC	Good	10
PL 2.2	NJ	**Risk description:** If we do not embed appropriate business case approval processes then plans will not be sustainable so we will not be able to meet the needs of patients and populations **Risk owner:** Deputy Director of Finance	4	4	16	• Working group to inform SLG decisions • Business case templates and corporate report front-sheets	Requires Improvement	• Working Group papers • External approval of business cases e.g. NHP	Requires Improvement	10
PL 2.3	PG	**Risk Description:** If we do not work to improve our sustainability as an organisation then we will increase our environmental impact and so we will not improve the environmental, social and economic well-being of our communities, populations and people. **Risk Owner:** CFO	3	3	9	• Sustainability champions & Sustainability Travel Working Group in place at DCH to encourage long term improvements and sustainability • Sustainability Programme in development in line with the Kings Fund Sustainability Theory bringing together Social, Environmental and Economic factors • Social Value Pledge and Action Plan in place emphasising the commitment to improving the wellbeing of the population • Green plan published and monitored annually • Planned revision of annual report to support triple bottom line reporting	Good	• Regular reporting to Strategy and Transformation SLG • Annual reporting on Green Plan to FPC and Board	Good	9
Place Objective 3: We will utilise digital technology to better integrate with our partners and meet the needs of patients										

PL 3.1	SS	**Risk description:** Not achieving a Dorset wide integrated electronic shared care record **Risk owner:** CIO	2	3	6	Dorset Care Record project lead is the Director of Informatics at Royal Bournemouth Hospital. Project resources agreed by the Dorset Senior Leadership Team. Project structure in place overseen by ICS Digital Portfolio Director	Good	• Reports to the Dorset System Leadership Team. Updates provided to Dorset Operation and Finance Reference Group and the Dorset Informatics Group.	Good	9
PL 3.2	SS	**Risk description:** Not providing adequate cyber security defences to protect the Trust's digital assets **Risk owner:** CIO	3	4	12	Patching of perimeter defences, firewalls, servers, switches, desktop/laptop equipment, penetration tests and regular audits	Good	• Annual Penetration Test Results and associated action plan • Annual DSPT submission • Regular reports to Quality Committee, Risk and Audit Committee, Trust Board	Good	9
PL 3.3	SS	**Risk description:** Trust staff not trained sufficiently to minimise targeted and social engineering threat attempts **Risk owner:** CIO	3	4	12	Part of DSPT annual assurance, digital training team providing training for all new starters and annual refresh training where required. Regular phishing campaigns.	Good	• Annual DSPT submission • Regular reports to Quality Committee, Risk and Audit Committee, Trust Board • Targeted training resulting from output of internal campaigns	Good	9
Place Objective 4: We will listen to our communities, recognise their different needs and help create opportunities for people to improve their own health and wellbeing and co-designing services										
PL 4.1	NL	**Risk description:** If we fail to engage and work with partners and stakeholders to effectively maximise the opportunities to engage and co-design with our communities then services will not be meeting the needs of those that use then. **Risk owner:** Alison Male: Patient engagement Jo Hartley: Maternity voices partners	3	4	12	• Your Voice group of service users • Maternity Voices Partners as part of the Local Maternity & Neonatal System • Communication and Engagement lead for estate development to support further engagement with local population • Learning Disability Advisor linked activity with independent groups of service users • Engagement roadmap with leadership from Head of patient Experience and Engagement • Networked links with external engagement partnerships such as Healthwatch Dorset, CCG/ICS team, Dorset Council • Council of Governors links into community coordinated by the Corporate Trust Secretary • Quality Improvement methodology includes service user engagement • Public Health networks into key work streams for population health and wellbeing (such as smoking cessation) • Health Inequalities group and networked activity across ICS to support engagement with diverse population • Communication teamwork across the ICS	Good	• PEG actions/ notes • Patient feedback • Healthwatch reports • CQC reports • Maternity Voices reports • Complaints including local MPs related to engagement • Local independent groups reports or complaints • Diis Data and Public Health reports • Health Inequalities data	Good	4
PL 4.2	NL	**Risk description:** If we fail to utilise population health data in a meaningful way to inform service development then services will not meet the needs of the population in ways that means an improvement in health and wellbeing **Risk owner:** Stephen Slough for Digital/BI Alison Male: patient feedback Alastair Hutchison: AHSN Nick Johnson: ICS	3	4	12	• DiiS dataset • Partnership in ICS with Public health and Local authority at PLACE level • Primary care Networks • Digital data sources with shared records • Business intelligence resources across the system • ICS Health inequalities group • ICS integrated working on pathways • Clinical networks membership with data sharing • Academic Healthcare science networks • ICS governance	Good	• HI group reports and actions • Benchmarking data • Patient feedback • Partners feedback • Data • National published reports or network reports • ICS Clinical reference group notes • National audits on outcomes	Good	4

Risk Ref:	Responsible Director	Risk Description/Risk Owner:	Consequence Score	Likelihood Score	Risk Score	Existing Mitigation/ Controls	Strength of Control	Assurance/ Evidence	Strength of Assurance	Target Risk Score
Partnership Objective 1: We will contribute to a strong, effective Integrated Care System, focussed on meeting the needs of the population										
PA 1.1	NJ	**Risk description:** If the Trust decision-making processes do not take due account of system elements then the Trust will not be able to engage proactively within the system so the impact of the Trust on the system will be diminished **Risk owner:** NJ	4	2	8	• SLG and Corporate Governance includes system updates and information • Membership of Provider Collaboratives and system other forums • Board feedback and monitoring of system engagement	Good	• SLG Meetings • Board and Committees • System Oversight Framework	Good	8
PA 1.2	SS	**Risk description:** If the Trust does not embed population health data within decision-making which highlights health inequalities then the Trust will not know if it is delivering services which meet the needs of its populations **Risk owner:** CIO	3	3	9	• Dorset Insight and Intelligence Service (DIIS) accessable and available to Trust • DIIS/BI dashboards on key trust metrics provided	Requires Improvement	• Health Inequalities Programme • Digital Portfolio Board	Requires Improvement	6
PA 1.3	AH	Failure to provide the environment to support MDT working within DCH and the ICS leading to unsustainable services and poorer outcomes. **Risk Owner:**	3	2	6	• Divisions supported by the Strategy and Partnerships Team (Estates/place based portfolio). • Development of the clinical strategy	Good	• Reporting through SLG	Good	6
PA 1.4	AH Could be split between AH/NJ/AT	Recovery of waiting lists plus increasing workload within the hospital may impair our ability to contibute effectively to the objectives of the ICS **Risk Owner:**	3	4	12	• Development of the Clinical and People Strategies, recognising the need for integrated working • Trust Board oversight and assurance of ICS Involvement in Elective Recovery Oversight Group with clinical leads present in key workstreams - MSK, Eyes, Endoscopy, ENT - opportunities noted and acted upon to share resource, space, ideas to maximise recovery as a system	Requires Improvement/ Good	• Monitoring and oversight of Trust Stratgegy and enabling strategies, reporting to Trust Board evidenced through papers and minutes - ECOG and associated workstream documentation	Good	6
Partnership Objective 2: We will ensure best value for the population in all that we do and we will create partnerships with commercial, voluntary and social enterprise organisations to address key challenges in innovative and cost-effective ways										
PA 2.1	PG	**Risk description**: Failure to deliver sustained financial breakeven and to be self sufficient in cash terms **Risk owner:** CFO	4	5	20	• ICS Financial framework and Financial Strategy. • Current short term plans delivering close to a breakeven and do not require external financing, but are heavily reliant on non recurrent funding.	Good	• ICS Financial framework and Financial Strategy • Reporting to Board, FPC and BVBCB.	Requires Improvement	12
PA 2.2	PG	**Risk description**: Failure to deliver sufficient Cost improvements and continue to be efficient in national financial benchmarking **Risk owner:** CFO	4	3	12	• Track record, PMO facilitating ideas for savings etc. • BVBCB, FPC and Board monitoring CIP plans and delivery	Good	• Model hospital, GIRFT reviews, Reference costs index, Corporate services benchmarking.	Good	9
PA 2.3	NJ	**Risk description:** If the Trust does not engage with commercial and VCSE sector partners then cost effective solutions to complex challenges will be restricted and so the Trust will be limited in the impact it is able to have **Risk owner:** NJ	3	2	6	• Commercial and Partnerships Strategy and Plan • VCSE engagement via patient and public engagement and charity teams. • SLG reporting	Good	• Commercial strategy delivery reporting • Your Voice Engagement Group • Social Value strategy oversight	Requires Improvement	6
Partnership Objective 3: We will increase the capacity and resilience of our services by working with our provider collaboratives and networks and developing centres of excellence We will work together to reduce unwarranted clinical variation across Dorset										
PA 3.1	AT	**Risk description:** If the Trust does not collaborate with provider partners through the ICS Provider Collaboratives and other existing clinical networks then sustainable solutions via collaboration will not be explored or adopted and so vfm, sustainability and variation of services for patients will not decrease sufficiently **Risk owner:** COO	4	2	8	• Engagement in current 'provider collaboratives' e.g. Elective Care Oversight, Home First etc, UECB, DCP • Commitment to be engaged fully in ICS 'Provider Collaborative' South Walks initiative with system partners including Local Authority and community provider	Good	• Reporting to Trust Board and FPC • System documentation for Home First, Urgent and Emergency Care Board, Elective Care Oversight Group including Deep Dives and SRO roles, work-stream specific documentation	Good	8
PA 3.2	NJ	**Risk description:** If the Trust does not initially support the appropriate delegation of authority to the Provider Collaborative and then does not adequately acknowledge and accept the delegation then effective functioning of the Provider Collaborative will not be possible and appropriate and measured solutions which improve sustainability and reduce variation will not be implemented **Risk owner:** NJ	4	2	8	• Engagement of Trust Board in ICS discussions and planning • Trust Board review and approval of any delegation. The Trust has a legal obligation to collaborate outlined in the amended provider licence	Good	• Trust Board papers	Good	8
PA 3.3	NJ	**Risk description:** If the Trust does not invest and support key services identified as 'centres of excellence' by the clinical strategy then investment into key services integral to the future sustainability of the Trust will not be forthcoming **Risk owner:** CMO	4	4	16	• The Clinical Strategy will set out the areas for investment and prioritisation. • Investment through business planning will be aligned to clinical strategy to ensure investment in key areas which are integral to the future sustainability if the Trust • Review of investment and impact via divisional performance framework and sub-committee structure.	Good	• Monitoring of clinical strategy via S&T SLG and divisional performance • Business Planning processes	Good	8
Partnership Objective 4 Through partnership working we will contribute to helping improve the economic, social and environmental wellbeing of local communities										
PA 4.1	NJ	**Risk description:** If the Trust does not recognise the impact of it's decisions on the wider economic, social and environmental well-being of our local communities then our impact will not be as positive as it could be and so the health our populations will be affected **Risk owner:** NJ	3	3	9	• Social Value Programme. • Social Value Impact Assessments against decision • Reporting of social value programme progress and impact against social value plan to SLG and Trust Board.	Good	• Social Value reporting to SLG and Board • SV Dashboard • SV reporting in annual report	Good	6

		LIKELIHOOD SCORE				
		1	2	3	4	5
CONSEQUENCE SCORE		Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic		5	10	15	20	25
4 Major		4	8	12	16	20
3 Moderate		3	6	9	12	15
2 Minor		2	4	6	8	10
1 Negligible		1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

0 - 4	Very low risk
5 - 9	Low risk
10 -14	Moderate risk
15 – 19	High risk
20 - 25	Extreme risk

Likelihood score (L)

The Likelihood score identifies the likelihood of the consequence occurring.

A frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur 1 in 3 years	Do not expect it to happen/recur but it is possible it may do so 1 every year	Might happen or recur occasionally 1 every six months	Will probably happen/recur but it is not a persisting issue 1 every month	Will undoubtedly happen/recur,possibly frequently 1 every few days

Identifying Risks

The key steps necessary to effective identify risks from across the organisation are:

a) Focus on a particular topic, service area or infrastructure
b) Gather information from different sources (eg complaints, claims, incidents, surveys, audits, focus groups)
c) Apply risk calculation tools
d) Document the identified risks
e) Regularly review the risk to ensure that the information is up to date

Scoring & Grading

A standardised approach to the scoring and grading risks provides consistency when comparing and prioritising issues.
To calculate the Risk Grading, a calculation of **Consequence (C)** x **Likelihood (L)** is made with the result mapped against a standard matrix.

Consequence score (C)

For each of the five main domains, consider the issues relevant to the risk identified and select the most appropriate severity scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column. This provides five domain scores.

DOMAIN C1: SAFETY, QUALITY & WELFARE

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality /audit	Peripheral element of treatment or service suboptimal	Overall treatment or service suboptimal Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Gross failure to meet national standards

DOMAIN C2: IMPACT ON TRUST REPUTATION & PUBLIC IMAGE

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Complaints	Informal complaint/inquiry	Formal complaint (stage 1) Local resolution	Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review)	Multiple complaints/ independent review	Inquest/ombudsman inquiry

DOMAIN C3: PERFORMANCE OF ORGANISATIONAL AIMS & OBJECTIVES

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5-10 per cent over project budget Schedule slippage	Non-compliance with national 10-25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Service/business interruption	Loss/interruption of >1 hour	Loss/interruption of >8 hours	Loss/interruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

DOMAIN C4: COMPLIANCE WITH LEGISLATIVE / REGULATORY FRAMEWORK

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required inadequateperformance rating Severely critical report

DOMAIN C5: FINANCIAL IMPACT OF RISK OCCURING

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Environmental impact	Minimal or no impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment

The average of the five domain scores is calculated to identify the overall consequence score

(C1 + C2 + C3 + C4 + C5) / 5 = C

Meeting Title:	Board of Directors Part 1
Date of Meeting:	26th January 2022
Document Title:	**Freedom to Speak Up Report Q1 & 2**
Responsible Director:	Julie Barber
Author:	Ulamila Brocklebank

Confidentiality:	No
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
People and Culture Committee	15th November 2021	

Purpose of the Paper	To provide an update Freedom to Speak Up cases raised in Quarter 1 & 2 2021/22 and activities to date. Outline plans moving forwards.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	FTSUG has been in post since early August 2021. The FTSUG as used Quarter 1 & 2 to raise awareness of the 'Freedom to Speak Up' culture. As the post has been extended to a full time post the FTSUG has been able to get out across the Trust. The number of people speaking up are starting to increase slowly. Increasing the number of champions across the trust will raise the awareness of speaking up as a normal part of business. The cases being raised are very varied across the trust. Areas to be addressed are middle managers understanding of what is expected from them and how this can be monitored going forward. Incivility and strained relationships with direct line managers are key areas to be addressed.							
Action recommended	The Board is recommended to: 1. **NOTE** the Update on FTSU 2. **APPROVE** the proposed plans for FTSU work							

Governance and Compliance Obligations

Legal / Regulatory	Y	Contractual requirement to have FTSUG. Reporting follows national guidelines.
Financial	N	
Impacts Strategic Objectives?	Y	Trust Priorities 2021- Supporting each other, delivering safe & compassionate care
Risk?	N	
Decision to be made?	N	
Impacts CQC Standards?	Y	Links to well-led leadership & management promoting open & fair culture
Impacts Social Value ambitions?	Y	Recognised as a Good Employer, ensuring employees have a positive & fulfilling experience
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Quarterly Freedom to Speak Up Report

Q1 & 2. April – September 2021/2022

1.0 Introduction

1.1 It is a contractual requirement for all NHS provider Trusts to have a Freedom to Speak Up Guardian. The Guardian's key role is to support the creation of a positive, open learning culture where our people feel listened to, and feedback is welcomed, and acted on.

1.2 The Trust has been successful in employing a full time Freedom to Speak Up Guardian. The current FTSUG came into post at the start of August 2021.

1.3 The FTSUG provides six-monthly updates to the Trust Board, as recommended by the National Guardian's office. As requested at the People and Culture Committee in January, a quarterly report will be provided to that committee moving forward. In this report the break down will be split into sections 'speaking up' Listen up' and 'Follow up.'

2.0 Speaking Up

2.1 As part of FTSU month, the FTSU Guardian has continued to raise awareness of the role, both by physical presence across the hospital and using a promotion event in Damer's Restaurant using a prize draw. The details from this event allowed the collation of information such as how people would prefer to speak up, it identified work areas that will need to be visited to raise awareness in the future. The FTSU Guardian will continue to enact the next steps detailed in section 5.0.

2.2 Eleven members of staff have stepped forward to become FTSU champions bringing the number up to 18 with a target of 20 by December 2021. The aim is to encourage a 'speak up' culture across the trust. In November all FTSU champions will commence training to National Guardian Office (NGO) standard.

2.3 Listen Up

2.4 As part of 'Listening up' managers have responded in a number of ways; it has been identified as an area that needs work. One of the benchmarks of the FTSUG is to close cases in a timely manner. In many Trusts this is done by completing within 21 days of being raised to the managers, although it is recognised that some cases will take longer and will be on going. It is therefore recognised that there is no robust system in place. Plans to tackle this will be discussed in 5.1 and 5.4.

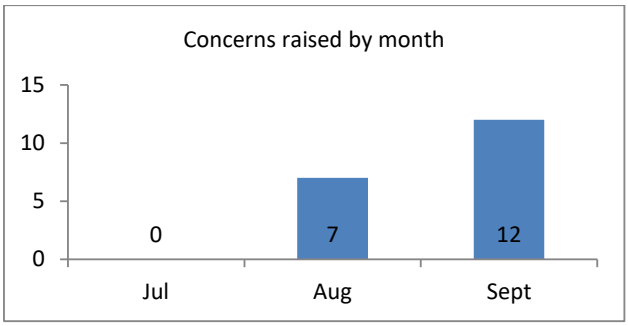
2.5 Training needs for managers are ongoing within the Trust as highlighted in 5.3

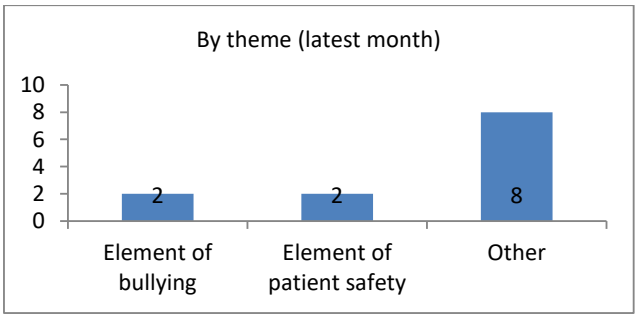
2.6 **Follow Up**

Trust Executives demonstrated commitment to a speak up culture by making Pledges for the FTSU display in Damer's Restaurant in October 2021. The Training for Executives is still to be introduced as part of the 'Follow up' being introduced by the National Guardian office in 2022.

3.0 Reporting Speaking Up Cases

Freedom to Speak Up concerns





3.1 The FTSUG submits Quarterly DCH Speaking Up data online via the NGO Portal. This is published nationally alongside all other NHS Trusts' data. During Quarter 1 & 2, 21 cases were raised.

4.0 Subjects Raised in Quarter 2 and Emerging Themes

4.1 The themes raised during July/August/September 2021 have been very varied, these are presented as a list this Quarter as part of the FTSUG learning has been to learn the process around the job.

The themes include:

- No confidence in the leadership of the management team
- Not being paid monies for shifts already completed
- No access to a toilet for patients
- Detriment due to speaking up
- Agency workers not following up on the completion of basic nursing observations (fluid charts) on shifts.
- Racial abuse by a patient toward agency staff, who did not feel supported by the sisters on the ward who were present at the time.
- Sisters setting themselves up with a contract and putting themselves on courses over others before retirement (highlighted in an anonymous letter).
- Leavers not receiving the leavers questionnaires.
- Issues of Incivility have also been impacting teams.
- A manager was concerned that new HCAs are put straight into high pressure wards setting them up for failure and then they leave the Trust.

4.2 Only one case has been closed and has given feedback they would speak up again.

5.0 Next Steps

5.1 National Guardian Office case studies for other NHS Trust have been reviewed for areas that needed improvement. One improvement identified in Whittington NHS Trust was the implementation of an electronic database designed by their HR team to help with completion of cases. The HR team were able to follow up the process after being raised by the FTSU Guardian. The FTSG will work with HR team to design a spreadsheet to help with issues being addressed and ensure cases are followed up in a timely manner.

5.2 Highlighted in the Quarter 4, 2020/2021 report, the Leading and Managing for Inclusion Programmes have commenced with good feedback, raising awareness and prompting new ways of thinking and working.

5.3 FTSUG has been working closely with the OD team. The FTSU guardian will work with the OD team to improve staff experience including the enhancement of a ‘Leadership and Management’ tool kit regarding issues identified from ‘Listening up’ 2.5.

5.4 As identified in the ‘Listen Up’ 2.4 Managers should have clarification on the process of their responsibilities to complete the listen up part of the process with clear deadlines including completing in a timely manner and reporting to HR. To be discussed with HR (see 5.1).

5.5 The FTSUG will start the process of training with all Champions and the HR team. Housekeeping team will also be included in this as this has been highlighted as one team struggling. As suggested by the National Guardian office this will include ‘Education for Health’s’, ‘Freedom to Speak up’ training.

5.6 An increased focus on encouraging individuals to take responsibility for the impact of their behaviours on others will be achieved through working with the OD Team and all staff completing Education for Health training. The programme of work around Leading and Managing for Inclusion and Dignity and Respect at Work will raise awareness and encourage behaviour change. The FTSUG and Champions' Network will collaborate in the development of staff to create a more respectful and meaningful culture and for the early resolution of issues with the aim of creating a culture of psychological safety.

6.0 Conclusion

6.1 The FTSU Guardian role supports the creation of a positive culture and environment for raising concerns, protecting patient safety and quality of care, improving the experience of staff, and promote learning and development. Ensuring a preventative approach is more likely to lead to informal resolution of relationship issues in the workplace.

6.2 Creating a team of FTSU champions across the trust will help raise the 'Speak Up' culture and help the staff understand the routes that are available and how to 'Speak Up'.

6.3 The FTSU service will start the process of implementing a robust reporting route to work with line managers to assure responsibility is taken to address concerns and assure progress to address issues raised including ensuring feedback is given to staff.

6.4 Working with the OD team to identify and implement interventions, promoting and taking actions on a variety of programmes and strategies including the 'Manager's tool kit' identifying training needs of the Trust. This will be the focus of the Freedom to Speak Up Guardian over the next coming months.

Meeting Title:	**Board of Directors Part 1**
Date of Meeting:	**26th January 2022**
Document Title:	**Mortality Report: Learning from deaths Qtr 2 2021/22**
Responsible Director:	Prof. Alastair Hutchison, Medical Director
Author:	Prof. Alastair Hutchison, Medical Director

Confidentiality:	Public
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Hospital Mortality Group	16th Nov 2021	None specific
Quality Committee	16th Nov 2021	

Purpose of the Paper	To inform the Board of the learning that has occurred as a result of deaths being reported, investigated and appropriate findings disseminated throughout the Trust.
Summary of Key Issues	The Trust's SHMI reported during Q2 (5 months in arrears - rolling years to March, April and May 2021) rose each month to clearly above the expected range in May at 1.1799 vs 1.1303. This is certainly being influenced to a large extent by delays in coding (reasons for this are explained within). No other local or national indicators suggest that standards of in-patient care are resulting in excess unexpected deaths at DCH. Structured Judgement Reviews are being used to examine the care of an appropriate sample of people who died whilst in-patients, and to learn from any lapses in care that are identified. The DCH Medical Examiners review every death and highlight any obvious causes for concern.
Action recommended	The Board is recommended to: 1. **NOTE** the report 2. **APPROVE** the report for publication on the DCH internet website 3. **Not publish** appendices 1 and 2 which are for internal discussion only

Governance and Compliance Obligations

Legal / Regulatory	Y	Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Publication on a quarterly basis is a regulatory requirement.
Financial	Y	Failure to learn from deaths could have financial implications in terms of the Trust's claim management and CNST status.
Impacts Strategic Objectives?	Y	Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Ensuring that an elevated SHMI is not a result of lapses in care requires regular scrutiny of a variety of data and careful explanation to staff and the public. An elevated SHMI can have a negative impact on the Trust's reputation both locally and nationally.
Risk?	Y	• Reputational risk due to higher than expected SHMI • Poor data quality can result in poor engagement from clinicians, impairing the Trust's ability to undertake quality improvement • Clinical coding data quality is improving, but previously adversely affected the Trust's ability to assess quality of care • Clinical safety issues may be reported erroneously or go unnoticed if data quality is poor

Decision to be made?	N	
Impacts CQC Standards?	Y	An elevated SHMI will raise concerns with NHS E&I and the CQC. NHS-I undertook a review in March 2019 and produced a report which has resulted in an action plan. This plan was presented to Trust Board in July 2019 and is complete, but work continues. The previous reduction in SHMI and improvements in coding are acknowledged, but have now reversed.
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

CONTENTS

1.0 DIVISIONAL LEARNING FROM DEATHS REPORTS
2.0 NATIONAL MORTALITY METRICS AND CODING ISSUES
3.0 OTHER NATIONAL AUDITS/INDICATORS OF CARE
4.0 QUALITY IMPROVEMENT ARISING FROM SJRs
5.0 MORBIDITY and MORTALITY MEETINGS
6.0 LEARNING FROM CORONER'S INQUESTS
7.0 LEARNING FROM CLAIMS Q4
8.0 SUMMARY

1.0 DIVISIONAL LEARNING FROM DEATHS REPORTS

Each Division is asked to submit a report outlining the number of in-patient deaths, the number subjected to SJR, and the outcomes in terms of assessment and learning. See appendix 1 and 2 for full reports.

1.1 Family Services and Surgical Division Report - Quarter 2 Report

Structured Judgement Review Results:
The Family Services & Division had 40 deaths in quarter 2 that require SJR's to be completed, with 15 having had a SJR completed. Between July to September, 32 SJR's have also been completed from previous months.

SJR Backlog:
The outstanding SJR's for the Division as at 15/10/2021 is 29:

May	July	August	September
4	7	12	6

The available notes have been allocated to Clinical staff to ensure these are completed.

Feedback from SJR's completed in quarter 2:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	1	11	23	31	4	0
1 Very Poor	0	0	0	0	1	0
2 Poor	0	1	0	0	2	2
3 Adequate	9	3	3	3	6	4
4 Good	16	21	14	7	15	24
5 Excellent	21	11	7	6	19	17

Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
2	0	4	6	24	11

- Loose sheets
- Notes incompletely photocopied
- Writing sometimes difficult to read but the time stamps are good and names are printed clearly

Avoidability of Death Judgement Score:

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Possibly avoidable but not very likely (less than 50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	1	0	2	5	39

Report completed by:
Richard Jee – Divisional Mortality Lead
Laura Symes – Quality Manager

1.2 Division of Urgent & Integrated Care Q2 Report

Structured Judgement Review Results:

The Urgent & Integrated Care Division had 153 deaths in quarter 2, of which 42 required a SJR to be completed. 15 of the 42 have completed SJR's, with 25 SJR's completed between July to October from previous months.

SJR Backlog:

The outstanding SJR's for the Division as at 03/11/2021 is 49:

June	August	September	October
2	8	19	20

The available notes have been allocated to Clinical staff to ensure these are completed.

Feedback from SJR's completed in quarter 2:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	3	9	35	40	10	2
1 Very Poor	0	0	0	0	0	0
2 Poor	1	1	0	0	1	3
3 Adequate	2	6	0	0	3	6
4 Good	23	23	3	0	17	26
5 Excellent	11	1	2	0	9	3

Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
4	0	1	3	27	5

- Notes on DPR, difficult to review resource intensive
- Clear and thorough documentation from nursing, ED and intensive care staff
- Death noted in medical notes but not in the EOLCP
- Although loose, the documentation by all health professionals is good once found
- It is difficult when the nursing notes were sometimes in the main clinical notes and sometimes in the AIRS document.

Avoidability of Death Judgement Score:

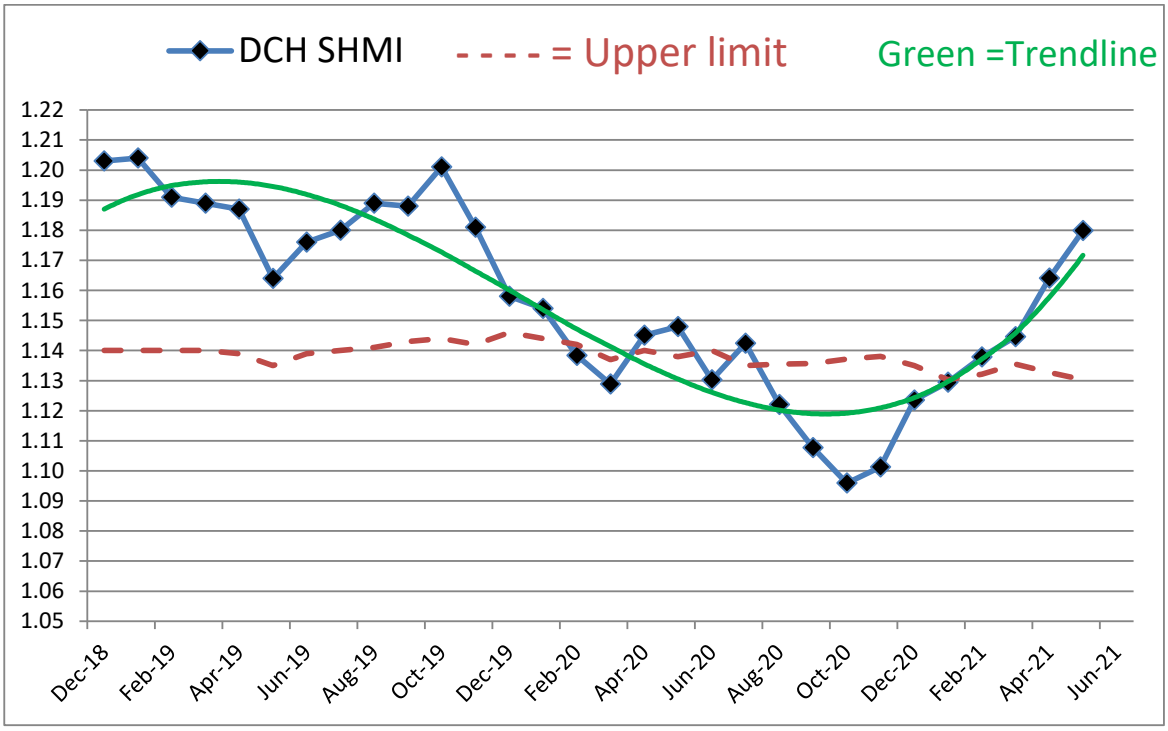
Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Possibly avoidable but not very likely (less than 50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
1	2	6	2	6	22

Sonia Gamblen, Divisional Head of Nursing & Quality
James Metcalfe, Divisional Director

2.0 NATIONAL MORTALITY METRICS AND CODING ISSUES

2.1 Summary Hospital-level Mortality Indicator (SHMI)

SHMI is published by NHS Digital for a 12 month rolling period, and 5 months in arrears. It takes into account all diagnostic groups, in-hospital deaths, and occurring those within 30 days of discharge. The SHMI for the rolling years from October 2020 to date shows a clear reversal of the previous trend to improvement. The latest SHMI is clearly outside of the expected range.



SHMI is calculated by comparing the number of observed (actual) deaths in a rolling 12 month period to the expected deaths (predicted from coding data). From October 2019 onwards there had been a steady improvement in DCH's SHMI as a result of investment in the coding department which resulted in more accurate and timely coding returns to NHS Digital.

As part of the NHS recovery from Covid-19, Trusts were financially incentivised to demonstrate that they were achieving at least 85% of the elective activity levels previously achieved in 2019. This required the coding department to concentrate on returns for elective activity, resulting in a risk that non-elective data (which makes up the vast majority of SHMI data at DCH) might not be coded in time to be included in SHMI. Unfortunately this risk has materialised and we can see several pieces of data (rolling year to May 2021) that suggest the SHMI is being adversely influenced as a result:

2.2 Percentage of provider spells with a primary diagnosis which is a symptom or sign: NHS Digital states "*This indicator presents the percentage of finished provider spells with a primary diagnosis which is a symptom or sign (identified by ICD-10 codes beginning with the letter 'R'). A high percentage of provider spells with a primary diagnosis which is a symptom or sign compared to other similar trusts may indicate problems with data quality or timely diagnosis of patients*".

DCH has the highest number of spells with a primary diagnosis which is a symptom or sign – for example 'chest pain' rather than 'myocardial infarction' – at 29.7% May 2021 versus 13.3% Oct 2020. Such spells are attributed a low risk of death since a symptom or sign only, does not suggest a life-threatening illness. The table below shows the 10 Trusts with the highest percentage of symptoms and signs instead of a primary diagnosis. For comparison the 10 best performing Trusts in this category all achieve less than 10%.

Provider Name	Symptom or Sign	Total spells	Percentage symptom or sign
DORSET COUNTY HOSPITAL NHSFT	**7,215**	**24,295**	**29.7**
MID AND SOUTH ESSEX NHSFT	46,745	167,460	27.9
ROYAL FREE LONDON NHSFT	25,750	95,940	26.8
TORBAY AND SOUTH DEVON NHSFT	10,700	42,080	25.4
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHST	20,295	89,590	22.7
LIVERPOOL UNIVERSITY HOSPITALS NHSFT	21,400	95,390	22.4
ISLE OF WIGHT NHS TRUST	3,600	18,480	19.5
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHSFT	7,835	40,600	19.3
NORTHUMBRIA HEALTHCARE NHSFT	14,490	75,305	19.2
MEDWAY NHSFT	9,470	50,580	18.7

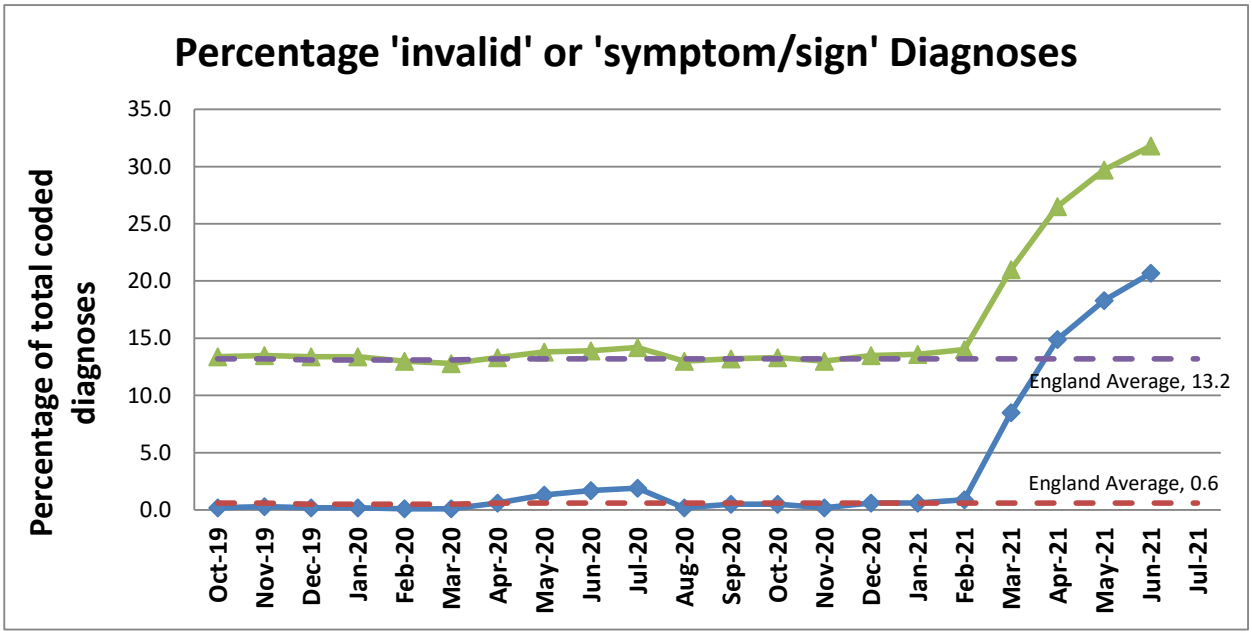
2.3 Percentage of provider spells with an invalid primary diagnosis code: NHS Digital states "*This indicator presents the percentage of finished provider spells with an invalid primary diagnosis code (identified as those spells where the primary diagnosis is given by the ICD-10 code R69X). A high percentage of provider spells with an invalid primary diagnosis code compared to other trusts may indicate a data quality problem*."

This metric is a subgroup of 2.2 above. A 'spell' is a continuous period of in-patient care.

The table below is taken from the latest SHMI publication (https://digital.nhs.uk/data-and-information/publications/statistical/shmi/2021-10/primary-diagnosis-coding) and shows that DCH now has the highest percentage of invalid primary diagnoses in the country (18.3% May 2020 versus 0.5% in Oct 2020). If these 'top 10' Trusts are discounted, the average for the rest of the country is 0.33%. Where no specific diagnosis is coded, such patients are attributed a low risk of death, which in turn reduces the Trust's 'Expected Number of Deaths', and therefore artificially increases the SHMI.

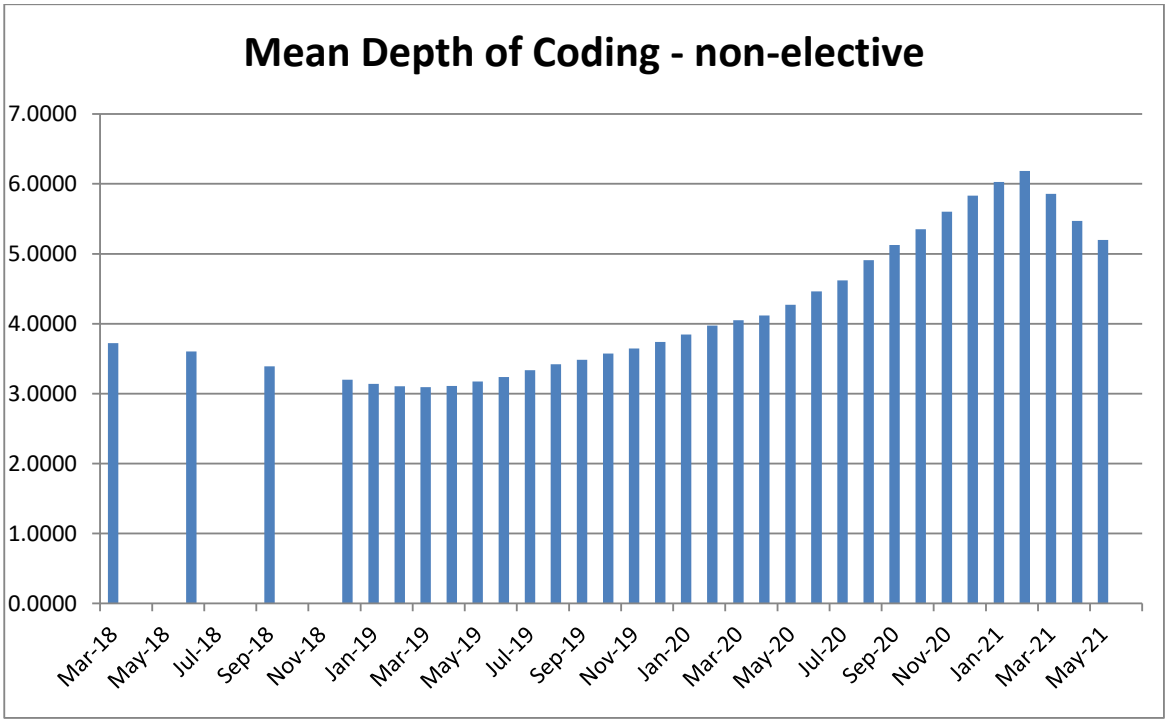
Provider Name	Invalid Primary	Total spells	Percentage invalid
DORSET COUNTY HOSPITAL	**4,435**	**24,295**	**18.3**
ROYAL FREE LONDON	16,860	95,940	17.6
MID AND SOUTH ESSEX	25,070	167,460	15
TORBAY AND SOUTH DEVON	4,760	42,080	11.3
ISLE OF WIGHT NHS Trust	1,465	18,480	7.9
THE ROTHERHAM NHSFT	1,755	39,250	4.5
UNIVERSITY COLLEGE LONDON HOSPITALS NHSFT	3,260	76,120	4.3
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHSFT	2,955	108,290	2.7
UNIVERSITY HOSPITALS PLYMOUTH NHSFT	1,540	64,460	2.4
BOLTON NHSFT	1,195	52,325	2.3

The graph below shows the change in these two metrics of coding accuracy over the past 30 months:



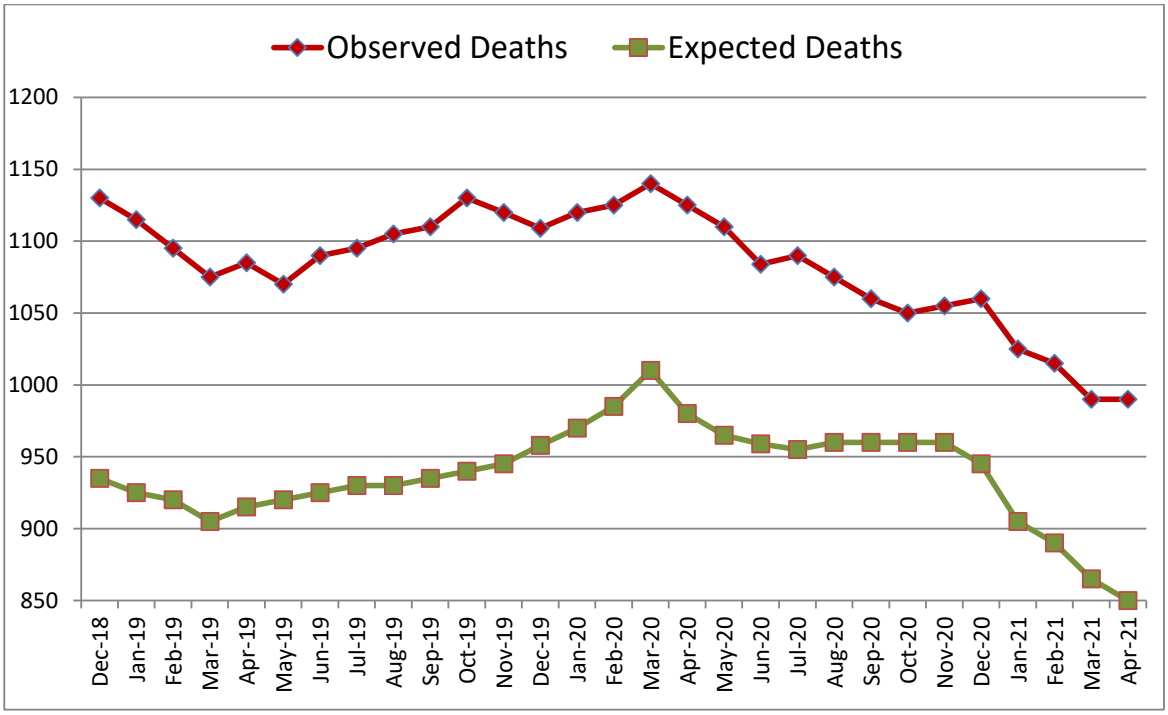
2.4 Depth of coding: NHS Digital states "*As well as information on the main condition the patient is in hospital for (the primary diagnosis), the SHMI data contain up to 19 secondary diagnosis codes for other conditions the patient is suffering from. This information is used to calculate the expected number of deaths. 'Depth of coding' is defined as the number of secondary diagnosis codes for each record in the data. A higher mean depth of coding may indicate a higher proportion of patients with multiple conditions and/or comorbidities, but may also be due to differences in coding practices between trusts*."

DCH's depth of coding had been increasing steadily up to February 2021 (see graph below), but is now decreasing and this is probably part of the same backlog problem in the coding department.



2.5 Expected Deaths (based on diagnoses across all admissions per 12 months):

The chart below shows observed and expected deaths over the past 3 years (rolling years from March 18 to April 21), and whilst our observed (actual) deaths continue to reduce, the expected deaths have reduced disproportionately faster as a result of included uncoded cases, thereby increasing the SHMI ratio.



2.6 Communication with NHS Digital:

From: CLINICAL INDICATORS, Hscic (NHS DIGITAL) <clinical.indicators@nhs.net>
Sent: 02 November 2021 09:44
To: HUTCHISON, Alastair (DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST) <alastair.hutchison@nhs.net>; **Cc:** NHS Digital
Subject: RE: [CMT-1808] Ref: NIC-599738-Z6M4M - SHMI

Hi Alastair,

Thank you for informing us of the problems at your trust with diagnosis codes. I can also see you have raised a query for your SHMI previewer data as well so I am answering that query as well as this one.
Invalid diagnosis codes are recoded by HES data processing rules to the code “R69X”, but the symptom / sign percentage covers any diagnosis code that starts with “R” including “R69X”. So the invalid diagnosis is a subset of the symptom/sign percentage. In the example you give it is 29.7% of your coding that potentially contains errors not 48%.
I can see that you have had a high percentage of this in recent months. If this issue is with 2021/22 provisional HES data then there may be opportunity to fix the issue in the coming months as we have nearly a year until the annual refresh of HES data takes place which will “finalise” the errors. You will need to contact our HES team about this.
I appreciate this higher percentage may be what is causing your SHMI value to be higher at the moment and that you don’t feel able to sign off your SHMI data as a result. I am happy for you not to sign off the data while this issue persists.
I hope this helps, but let me know if you have any further questions.

David Keighley (he/him)
Senior Information Analyst
Analytical Services – Population Health, Clinical Audit and Specialist Care: clinical.indicators@nhs.net

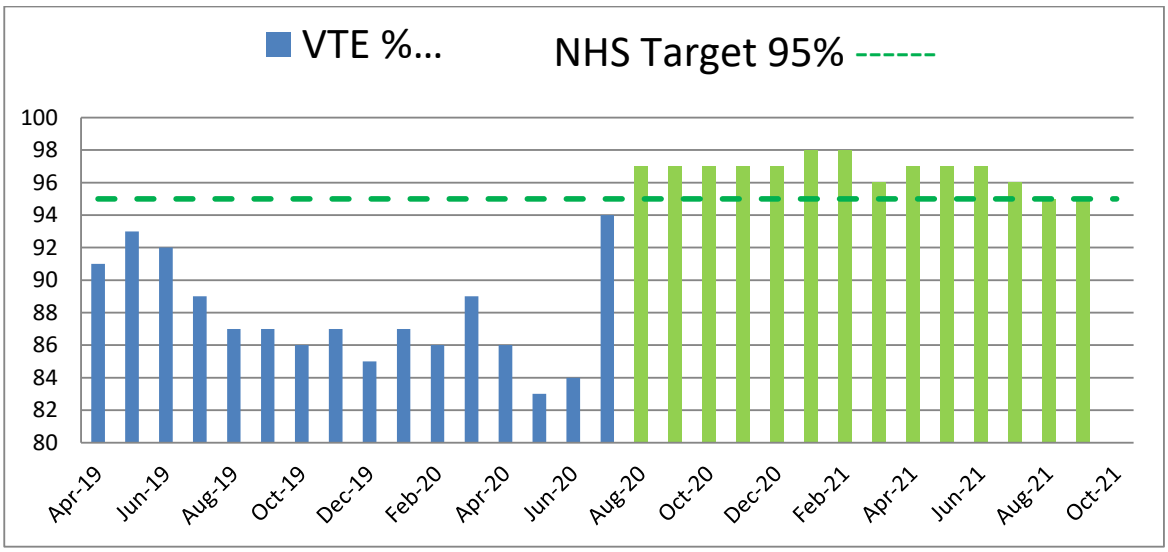
NHS Digital

3.0 OTHER NATIONAL AUDITS/INDICATORS OF CARE

The DCH Learning from Deaths Mortality Group regularly examines any other data which might indicate changes in standards of care, and has continued to meet on a monthly basis throughout the COVID-19 crisis. The following sections report data available from various national bodies who report on individual Trusts' performance.

For other metrics of care including complaints responses, sepsis data (on screening and 1 hour for antibiotic administration), AKI, patient deterioration and DNACPR data, please see the Quality Report presented on a monthly basis to Quality Committee by the Director of Nursing.

DCH VTE risk assessments reached 97% in August 2020 with the introduction of a more accurate reporting system, and have exceeded the 95% target for every month since then.

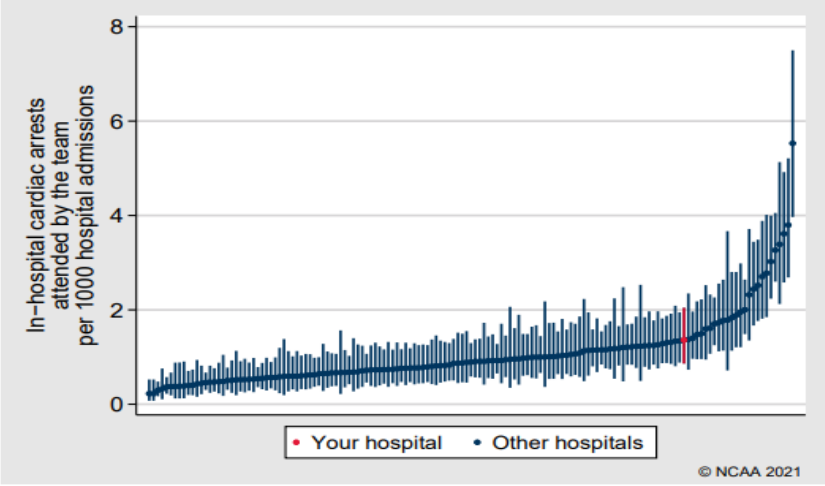


3.1 NCAA Cardiac Arrest data

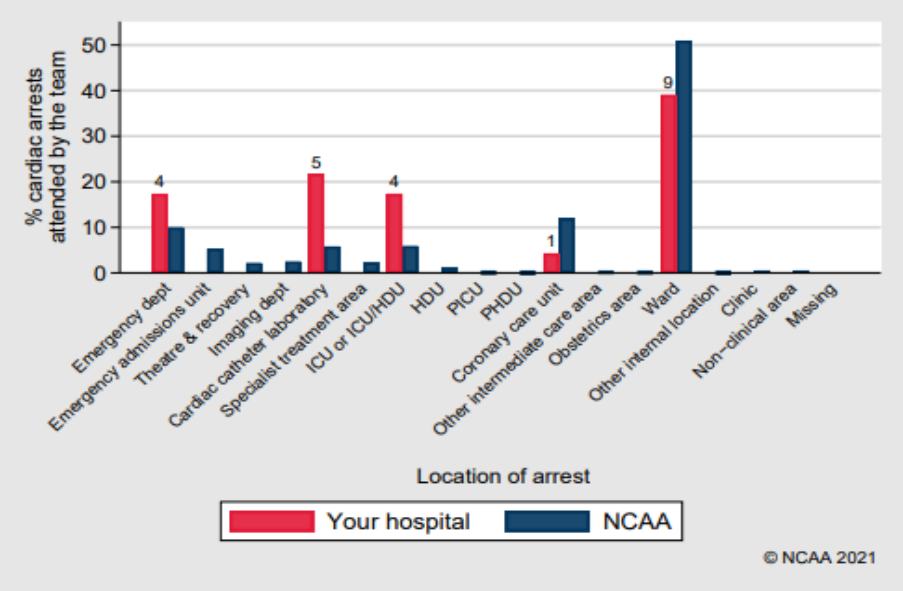
The national Cardiac Arrest audit for DCH April 2021 to June 2021 was published on 3/09/2021. A total of 23 cardiac arrest calls were recorded for this time period.

Rate of in-hospital cardiac arrests

The following graph presents the reported number of in-hospital cardiac arrests attended by the team per 1,000 hospital admissions for adult, acute hospitals in NCAA.

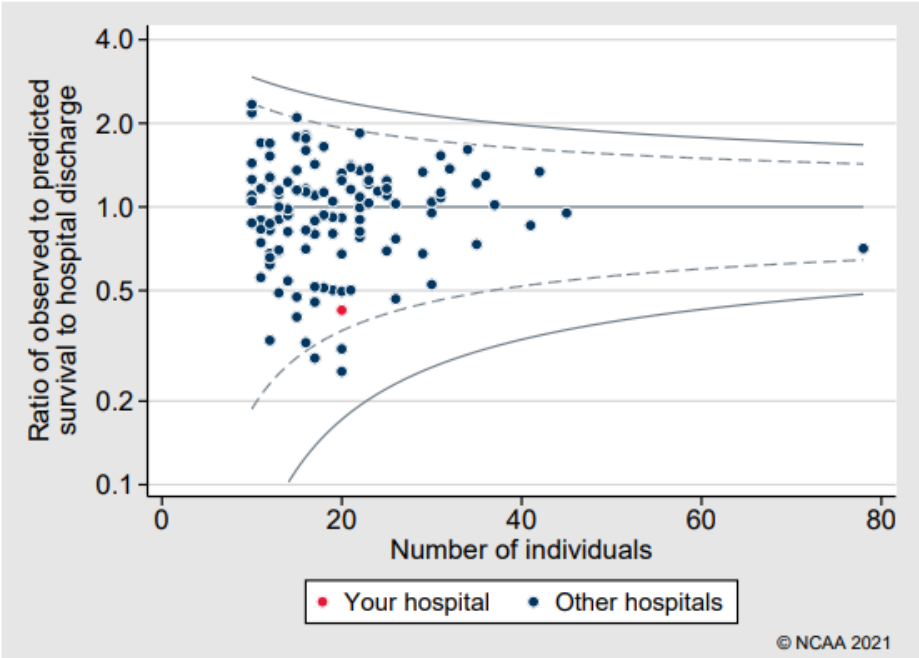


Location of arrest



Funnel plot of observed to predicted survival to hospital discharge

Higher is better



Your hospital	
Number of individuals	20
Number of observed survivors to hospital discharge	2
Number of predicted survivors to hospital discharge	4.7
Ratio of observed to predicted survival to hospital discharge	0.42
95% confidence interval	(0.12,1.28)

The graph above shows the ratio of observed to predicted survival, with DCH's result just above the lower 2 standard deviation funnel line indicating a result within the expected range. However the ratio is lower than previous quarters but the number of individuals contained within this calculation is very small (observed survivors 2, versus expected survivors 4.7). This metric will be carefully followed in the coming quarters.

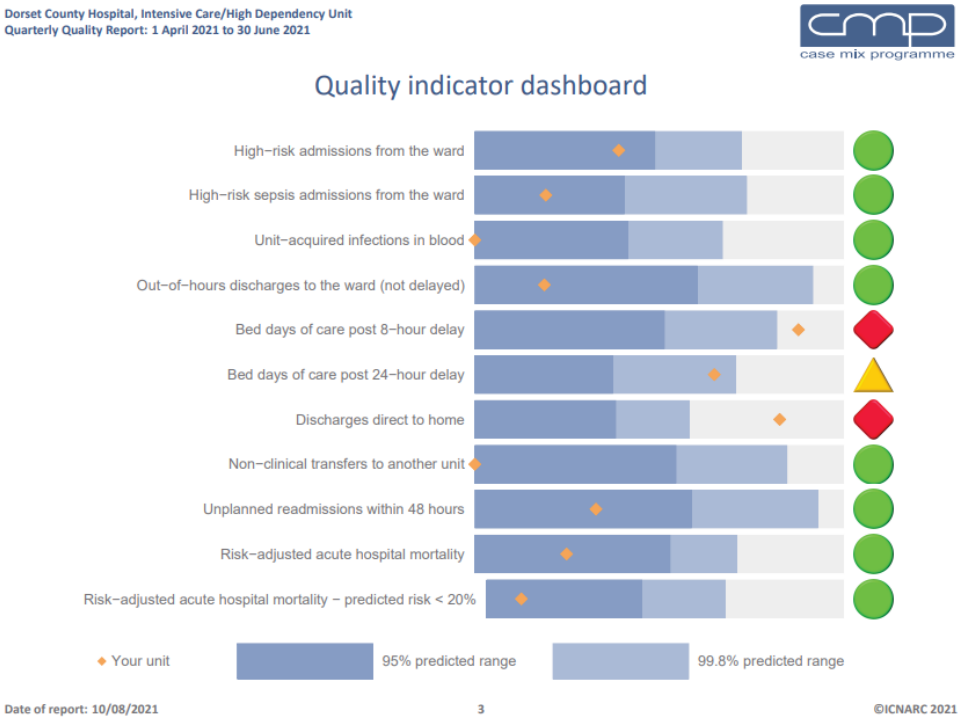
3.2 National Adult Community Acquired Pneumonia Audit latest data – last published Nov 2019, and not undertaken for either 2019/20 or 2020/21

Results Summary		Dorset County Hospital	National results
Patient Characteristics and Diagnosis		**n = 88**	**n = 10174**
Gender	Male Female	43% 57%	48% 52%
Age	Median (IQR)	78 (61-84)	75 (61-85)
Cohort Severity (CURB65 score)	0-1 2 3-5	42% 31% 27%	47% 29% 24%
Inpatient mortality	Proportion deceased	7%	10%
Length of stay (discharged patients)	Median in days	3	5
Critical care admission	Yes - proportion	2%	5%
Readmission	Yes - proportion	8%	13%

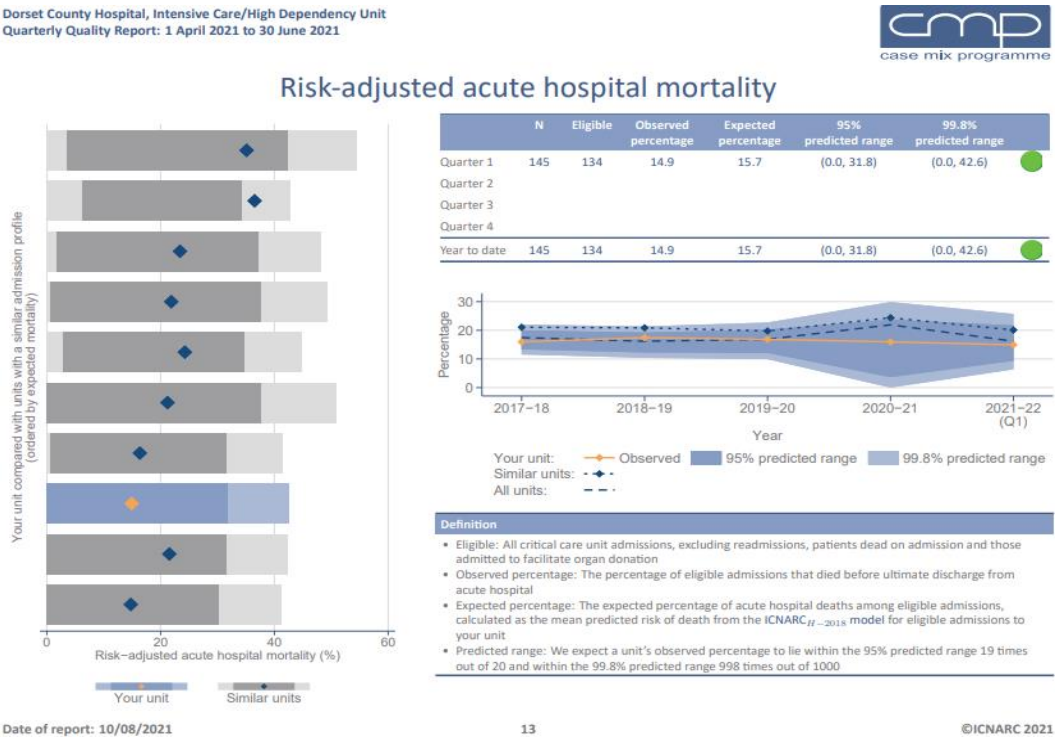
The results suggest that patients admitted to DCH 2018/19 tended to be more ill than the national average, but had a lower death rate and shorter length of stay, with fewer readmissions.

3.3 ICNARC Intensive Care survival latest data published 10 August 2021

The red and amber indicators in the chart below indicate delays in being able to discharge patients from ICU, with some delays being long enough that the patient was discharged direct to home

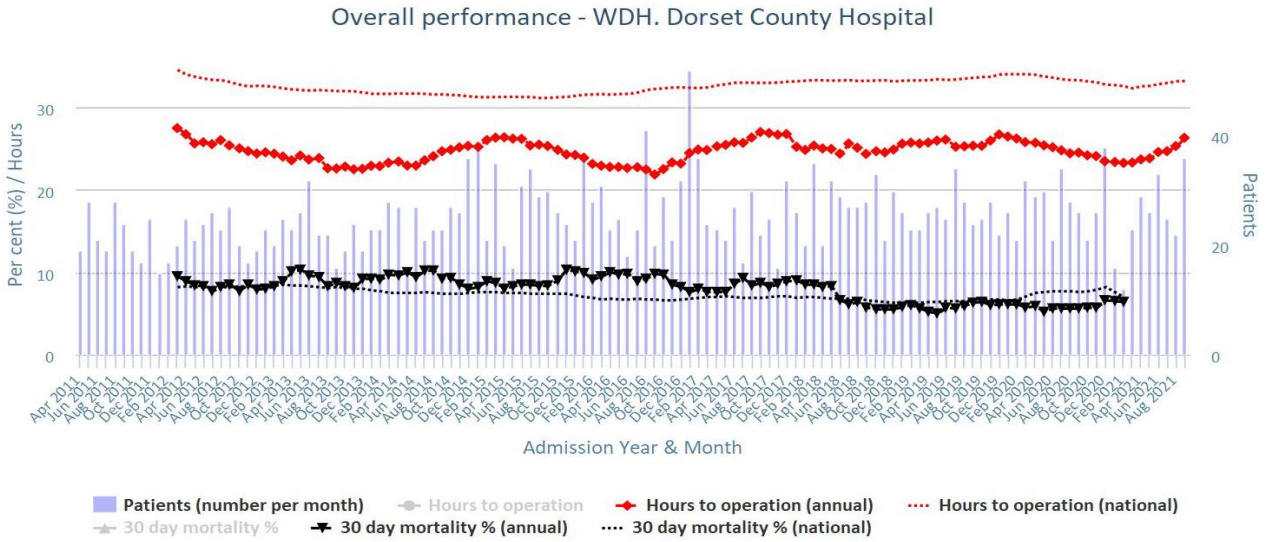


The charts below show the “risk adjusted acute hospital mortality” following admission to the DCH Critical Care Unit. They compare observed and expected death rates in a similar fashion to SHMI.



These results are comfortably within the expected range.

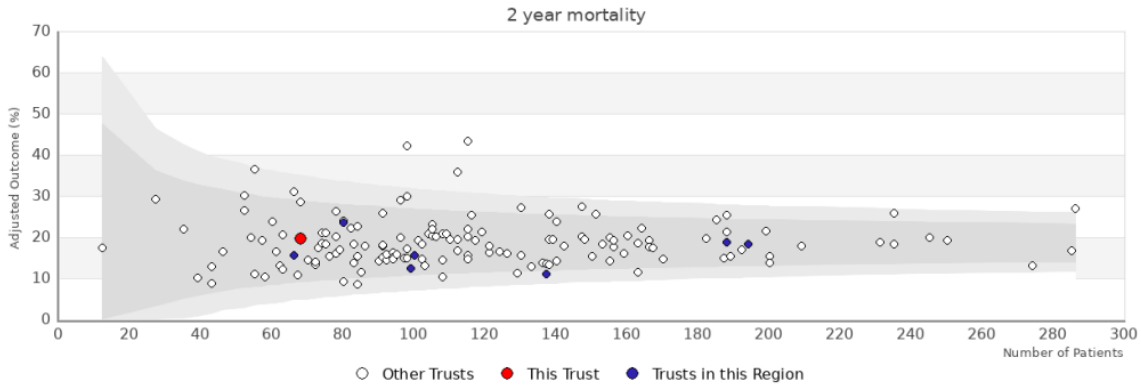
3.5 National Hip Fracture database to December 2020



The national average annualised mortality for hip fracture is 7.0%, with DCH's annualised mortality at 6.4% to February 2021 (latest available data).

3.6 National Bowel Cancer Annual audit

No new data as yet this year - graph below shows latest available 2 year survival data for patients admitted in financial year 2018/19, compared to all other NHS Trusts, with other Wessex Trusts in dark blue.



Trust	Number	Adjusted	Observed
Dorset County Hospital NHS Foundation Trust	68	19.7%	19.3%

3.7 Getting it Right First Time; reviews in Q2

One virtual GIRFT review was undertaken at DCH during this quarter – Rheumatology. The full report is available on request. No other visits took place during Q2.

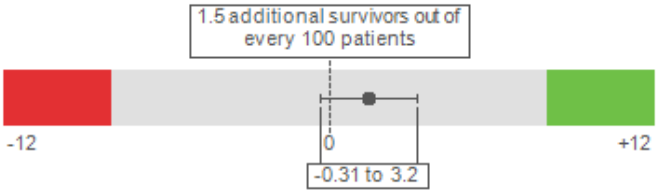
Full reports from all previous GIRFT visits are available, and feedback from each review has generally been very positive. Action plans have been developed and are being worked through at present.

3.8 Trauma Audit and Research Network

DCH is a designated Trauma Unit (TU) providing care for most injured patients, and has an active, effective trauma Quality Improvement programme. It submits data on a regular basis to TARN which then enables comparison with other TUs. Data for the period 1/1/18 to 31/5/21 is shown below, but data specific to Q1 and Q2 is not available at present:

Rate of Survival at this Hospital

Between January 1st 2018 and May 31st 2021



Rate of Survival Breakdown at this Hospital

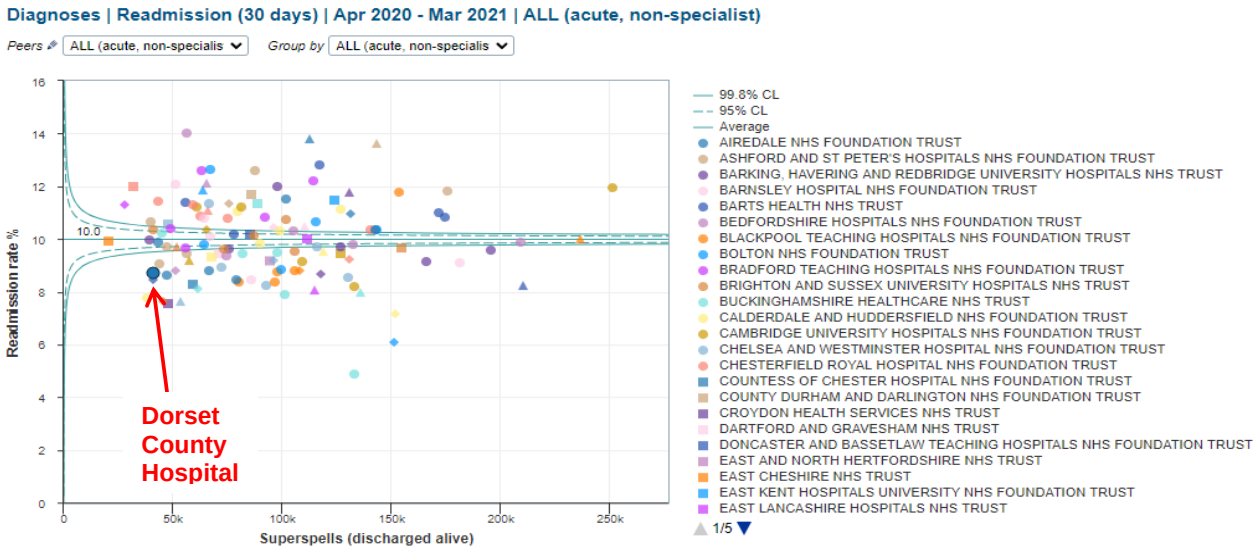
Survival band %	Number in group	Expected survivors	Actual survivors	Difference*	Adjusted difference**
95 - 100	429	420	425	1.0	0.6
90 - 95	155	144	142	-1.3	-0.2
80 - 90	95	81	85	3.8	0.3
65 - 80	34	25	23	-6.3	-0.2
45 - 65	13	7	12	33.1	0.7
25 - 45	3	1	2	28.7	0.5
0 - 25	3	0	0	-16.0	-0.2
Total	**732**	**680**	**689**	**1.1**	**1.5**

Unexpected deaths in minor/moderate injury
Usually due to poor management of co-morbidity and/or complications

Unexpected survivors with more serious injury
Usually indicates good initial resuscitation and the treatment of head injury in Neurological Centres

The first column categorises patients by percentage likelihood of survival, followed by the total number of patients seen at DCH, the calculated likely number of survivors and then the actual number of survivors.

3.9 Readmission to hospital within 30 days, latest available data (Dr Foster); lower is better



Readmission to hospital within 30 days suggests inadequate initial treatment or a poorly planned discharge process. However DCH's latest readmission rate is lower than the majority of other acute Trusts.

3.10 Dr Foster Safety Dashboard

This dashboard compares DCH with other England and Wales Trusts for a variety of complications that might occur during an in-patient stay or during childbirth. Where the confidence intervals (horizontal T bars) overlap the national mean there is no statistical difference from the national average. DCH has a higher number of decubitus (pressure) ulcers (264 versus 226; significant difference), but fewer deaths in low-risk diagnosis groups (24 versus 44; significant difference).

Patient Safety Indicators

Period: 12 months (Feb 20 to Jan 21) | Data lag: No lag

Indicator	Volume	Observed	Expected	Obs rate/k	Exp rate/k	Relative risk	Compare
Accidental puncture or laceration	28524	53	45.3	1.9	1.6	116.9	
Deaths after surgery	195	9	14.7	46.2	75.2	61.3	
Deaths in low-risk diagnosis groups	12626	24	44.2	1.9	3.5	54.3	
Decubitus ulcer	3785	264	225.9	69.7	59.7	116.9	
Infections associated with central line	5431	0	0.3	0	0.1	0.0	
Obstetric trauma - caesarean delivery	383	2	1.7	5.2	4.5	115.4	
Obstetric trauma - vaginal delivery with instrument	108	8	7.3	74.1	67.9	109.0	
Obstetric trauma - vaginal delivery without instrument	678	21	19.9	31.0	29.3	105.7	
Postoperative haemorrhage or haematoma	10920	4	4.1	0.4	0.4	98.1	
Postoperative physiologic and metabolic derangement	9377	0	1.7	0	0.2	0.0	
Postoperative pulmonary embolism or deep vein thrombosis	11005	33	30.3	3.0	2.8	109.0	
Postoperative respiratory failure	8572	5	8.8	0.6	1.0	56.6	
Postoperative sepsis	110	1	1.7	9.1	15.6	58.2	
Postoperative wound dehiscence	375	0	0.3	0	0.8	0.0	

4.0 QUALITY IMPROVEMENT ARISING FROM SJRs

The following themes have been previously identified from SJRs and are being translated into quality improvement projects:
a) Poor quality of some admission clerking notes, particularly in surgery
- The hospital clerking proforma has been revised, and the continuation note paper has had reminder watermarks added to remind staff to date, time, print name/GMC no.

b) Morbidity and Mortality meetings - standardization and governance (see next item)

5.0 MORBIDITY and MORTALITY MEETINGS

Morbidity and mortality meetings are continuing across the Trust, with minutes collated by Divisional Quality Managers.

Specialty	Contact	April	May	June	July	August
Cardiology	Helen Dell,	13.04.21	11.5.21	8.06.21	13.07.21	10.08.21
Renal	Kathleen O'Neill	05.05.21	02.06.21	30.06.21	28.07.21	28.08.21
Vascular	James Metcalfe	Weekly	Weekly	Weekly	Weekly	Weekly
Oncology	Abi Orchard				16.07.21	tbc
ED &Acute Medicine	Tamsin Ribbons & James Ewer	15.04.21	----------	Cancelled	----------	19.08.21
Respiratory	Marianne Docherty	27.4.21	25.5.21	Cancelled	27.07.21	24.08.21
Elderly Care & Stroke	James Richards Harold Proeschel	21.04.21	----------	----------	21.07.21	----------

6.0 LEARNING FROM CORONER'S INQUESTS Q2

DCH has been notified of 10 new Coroner's inquests being opened in the period July 2021 – September 2021.

7 other inquests were held during Quarter 2. 5 inquests were heard as Documentary hearings, not requiring DCH attendance. None required he clinician to attend Court in person. Two required attendance remotely from the DCH 'virtual courtroom' (in THQ) using Microsoft Teams.

We currently have 62 open Inquests. The Coroner has reviewed all outstanding cases to decide whether any can be heard as documentary hearings. 6 pre-inquest reviews were listed during this period.

We continue to work with the Coroner's office, and will continue to support staff at these hearings, an increasing number of which will be attended virtually. The virtual court room set up within Trust Headquarters appears to be working well, and Ms Mandy Ford (DCH) liaises with the coroner's officer to improve the technology and its use.

7.0 LEARNING FROM CLAIMS Q2

Legal claims are dealt with by NHS Resolution, who also produce a scorecard of each Trust's claims pattern and costs.

Claims pattern this Quarter:

New potential claims	7
Disclosed patient records	11
Formal claims	7 clinical negligence, 1 employee claim
Settled claims	4 clinical negligence, 1 employee claim
Closed - no damages	0

8.0 SUMMARY

SHMI has increased markedly to above expected range over the past few months. At least some of this change is likely to be a result of difficulties within the coding department which is manifest in the rise of uncoded 'Primary Diagnoses' to nearly 30%. No other metrics of in-patient care suggest that excess mortality is occurring at DCH, and much of the national data suggests better than average mortality.

Nevertheless the Hospital Mortality Group remains vigilant and will continue to scrutinise and interrogate all available data to confirm or refute this statement on a month by month basis. At the same time internal processes around the completion and recording of SJRs, M&M meetings and Learning from Deaths are now well embedded and working effectively within the Divisional and Care Group Teams.

Meeting Title:	Board Meeting
Date of Meeting:	26th January 2022
Document Title:	**Plan for the continued introduction of Midwifery Continuity of Carer (MCoC)**
Responsible Director:	Nicky Lucey, CNO
Author:	Jo Hartley, Associate Director of Midwifery & neonatal Services

Confidentiality:	
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**

Purpose of the Paper								
	Note		*Discuss*	✓	*Recommend*		*Approve*	✓

Summary of Key Issues	This paper outlines:
	• Background
	• Current position including
	  ○ Activity
	  ○ Imports and exports
	  ○ Current staffing
	• Staffing deployment plan with time scales and recruitment plan ensuring building blocks are in place
	• Framework of activities that will ensure readiness to implement and sustain MCoC
	• Time frame and monitoring process
	
	In line with Better Births and the NHS Long Term Plan, all women who receive antenatal, intrapartum and postnatal care from the same maternity service, should be offered the opportunity to receive the benefits of Continuity of Carer.
	
	Providing Continuity of Carer by default therefore means:
	
	1.Offering all women Midwifery Continuity of Carer as early as possible antenatally; and
	
	2. Putting in place clinical capacity to provide Continuity of Carer to all those receiving antenatal, intrapartum and postnatal care at the provider.
	
	DCH NHS FT aims to provide MCoC to 1500 women. The remainder of the women receive care from other maternity services but choose to give birth at DCH (approximately 200 women). Out of these women qualifying for CoC,							

	approximately 4% are Black, Asian, or Mixed ethnicity and do not live in a clearly defined geographical area Maternity services and LMS (or LMNS) are asked to prepare a plan to reach a position where midwifery Continuity of Carer is the default position model of care available to all women.
Action recommended	The Trust Board is recommended to: • Accept the contents of this report • Support maternity service in delivery of transformed model of care. • National guidance requires quarterly monitoring of this plan – agree for return of plan to board on a quarterly basis for review

Governance and Compliance Obligations

Legal / Regulatory	Y	This requirement links with the Maternity Incentive Scheme
Financial	Y	Additional funding to increase staff numbers has been identified through NHSE but the funding provided does not cover the cost of the total number of extra midwives required to provide a default CoC model.
Impacts Strategic Objectives?	Y/N	
Risk?	Y	Without an appropriately funded workforce, it will not be possible to reach the required default model
Decision to be made?	N	
Impacts CQC Standards?	Y	As above
Impacts Social Value ambitions?	Y/N	
Equality Impact Assessment?	Y/N	
Quality Impact Assessment	Y/N	

Dorset County Hospital
NHS Foundation Trust

Purpose of Report: For Board adoption and subsequent monitoring of a plan to achieve Midwifery Continuity of carer as the default model of care.

Maternity Board Paper.			
Agenda item:		**Enclosure Number:**	
Date:	December 2021		
Title:	**Plan for the continued introduction of Midwifery Continuity of Carer (MCoC)**		
Author /Sponsoring Director/Presenter	Jo Hartley, Associate Director of Midwifery & Neonatal Services Nicky Lucey, CNO		

Purpose of Report		Tick all that apply ✓	
To provide assurance	√	For discussion and debate	√
For information only		For approval	√
To highlight an emerging risk or issue		For monitoring	√

Summary of Report: *(Include key points and additional information as necessary regarding purpose of report- amend for your situation)*

This paper outlines:

- Background
- Current position including
  - Activity
  - Imports and exports
  - Current staffing
- Staffing deployment plan with time scales and recruitment plan ensuring building blocks are in place
- Framework of activities that will ensure readiness to implement and sustain MCoC
- Time frame and monitoring process.

Recommendation:

- Accept the contents of this report
- Support maternity service in delivery of transformed model of care.
- National guidance requires quarterly monitoring of this plan – agree for return of plan to board on a quarterly basis for review

Dorset County Hospital
NHS Foundation Trust

Background:

Midwifery Continuity of Carer has been proven to deliver safer and more personalised maternity care. Building on the recommendations of Better Births and the commitments of the NHS Long Term Plan, the ambition for the NHS in England is for Continuity of Carer to be the default model of care for maternity services, and available to all pregnant women in England. Where safe staffing allows, and the building blocks are in place this should be achieved by March 2023 – with rollout prioritised to those most likely to experience poorer outcomes first**.**

What does it mean to offer Midwifery Continuity of Carer as the default model of care?

In line with *Better Births* and the *NHS Long Term Plan*, all women who receive antenatal, intrapartum and postnatal care from the same maternity service, should be offered the opportunity to receive the benefits of Continuity of Carer. However, not all women will be in a position to receive continuity of carer, through choosing to receive some of their care at another maternity service. In a small number of cases, women will be offered a transfer of care to a specialist service for maternal / fetal medicine reasons.

Providing Continuity of Carer by default therefore means:

1. Offering all women Midwifery Continuity of Carer as early as possible antenatally; and
2. Putting in place clinical capacity to provide Continuity of Carer to all those receiving antenatal, intrapartum and postnatal care at the provider.

Maternity services and LMS (or LMNS) are asked to prepare a plan to reach a position where midwifery Continuity of Carer is the default position model of care available to all women.

As a first step, Local Maternity Systems (or and neonatal systems) agree a local plan that includes putting in place the 'building blocks' for sustainable models of Continuity of Carer by March 2022; so that Continuity of Carer is the default model of care offered to all women. This plan will include:

- The **number of women** that can be expected to receive continuity of carer, when offered as the default model of care
- **When** this will be achieved, with a redeployment plan into MCoC teams to meet this level of provision, that is phased alongside the fulfilment of safe staffing levels
- **How** continuity of carer teams are established in compliance with national principles and standards, to ensure high levels of relational continuity
- How **rollout will be prioritised** to those most likely to experience poor outcomes (although this is challenging and our CoC teams will be predominantly geographical
- **How care will be monitored locally**, and providers ensure accurate and complete reporting on provision of continuity of carer using the Maternity Services Data Set
- **Building blocks** that demonstrate readiness for implementation and sustainability assessment – ensuring all the key building blocks are in place.

Current position:

- Birth numbers used for the BR Plus assessment – 1670 (based on previous three years of data)
- Currently approximately 30 women have AN and PN care only from DCH but go out of area to give birth. This may change with access to a CoC team as currently these women are choosing the maternity unit that is geographically nearer. .
- Currently approximately 10% of women choose to travel to DCH for their birth. Anecdotally, this seems to relate to the layout of our rooms and the possibility of partners staying overnight in single rooms with mum and baby
- Number of women who are eligible for MCoC is approximately 1500. These are women living in the area who will be cared for by midwives from our service throughout their pregnancy episode (antenatal, intrapartum and postnatal).
- Only approximately 4% of women are Black, Asia or Mixed ethnicity. They are not all located in a single geographical area and with such small numbers it isn't possible to construct a CoC team focused solely on them. Therefore, they are included in the geographical teams
- BR Plus Safe Staffing Audit was completed in January 2021. In order to provide core services plus 51% of women receiving care from a CoC team, an extra 10.54wte midwives are needed. A calculation was not provided for CoC at full scale.
- The impact of the pandemic cannot be overestimated. Sickness rates are running at over 10% (a 3 fold increase) as well as those midwives who can't work because a member of their household has a positive PCR). It is a daily challenge to ensure safe staffing in the unit.

- Currently, the service has three CoC teams –
    - **Cranberry Team** – set up in Jan 2020 to provide continuity of care to the women and families in North Dorset. These women have mixed needs and are from a variety of ethnic backgrounds. There is a degree of social deprivation in the towns of Sturminster Newton and Blandford Forum, often requiring input from the Safeguarding Team. The team is 8 midwives which constitutes between 6-6.4wte. Each midwife has a caseload of around 27 women, this does fluctuate but on average it remains consistent. We have a continuity rate antenatally and postnatally of 100% and we have been able to offer intrapartum continuity to around 63% of the women. The team provided care to 174 women in 2020

    - **Cygnet Homebirth Team** – set up <6 years ago, to provide continuity of care for women choosing to birth at home. The team is 6 midwives which constitutes 4.7wte, plus a band 7 midwife who doesn't carry a caseload. Currently, women whose birth is changed to hospital because a caesarean is required or an induction of labour, do not receive intrapartum continuity. The team cared for 165 women in 2020.

- **Maumbury Team (specialist mental health CoC team)** – set up in May 2021 and comprises of two midwives. They have cared for 14 complex women (2 a month each) and have achieved continuity for 13 of them. Currently advertising for another midwife to join the team.

The Plan:

DCH NHS FT aims to provide MCoC to 1500 women. The remainder of the women receive care from other maternity services and are unlikely to change their position due to tertiary referral/geography etc. Out of these approximately 4% are Black, Asian, or Mixed ethnicity and do not live in a clearly defined geographical area.

MCoC teams should ideally be prioritised for roll out in the highest areas of Black, Asian and Mixed ethnicity populations and the postcodes of the lowest deciles as mapped in our Perinatal Equity and Equality Analysis. This ensures that we target women who are most likely to experience adverse outcomes first. However, given the rurality of West Dorset, CoC are set up geographically rather than around ethnicity, deprivation or co-morbidity.

Safe staffing:

1) Review the current funded establishment against a staffing tool such as Birthrate plus, for the traditional model of care. Birth rate plus considers activity and acuity to determine the midwife to birth ratio and recommends the number of midwives required to deliver care across the entire pregnancy and birth journey.
2) Variance remains between funded establishment and recommended. Investment from NHSE in relation to the Ockenden Report provided funding for 3.6wte extra midwives. Leaving a variance of 6.94wte midwives.
3) Recent recruitment has been poorly timed, based as it has been around specific vacancies and therefore missing the newly qualified midwives. This will be rectified in the future with recruitment planned for early 2022 to attract final year students. However they will not start work until October 2022.
4)
    i) Ensure current recruitment plans align with continuity of carer becoming the default model of care; including updating Job adverts and job descriptions.
    ii) Work with staff, HR and unions to agree on appropriate uplift or on call payments, considering LMNS wide agreement where appropriate or possible. Currently, staff in CoC teams have not requested uplift for their salary – preferring instead to be paid oncall in the normal manner.

Planning

1. Based on best evidence our MCoC teams will comprise mostly mixed risk geographical teams, where the lead midwife will follow the woman as necessary/ appropriate where specialist input is required.

2. We will not have specialist vulnerable women's groups as the evidence suggest that this does not improve outcomes and the women themselves prefer to receive place based (geographical) care.
3. We also want to manage the flow well by keeping the system as simple as possible – each midwife picking up 3-4 women per month and birthing 3 women per month, in this way we know that every woman will have a midwife at any given time.
4. Before we can commence any further CoC teams, we need to secure funding and then recruit midwives to meet the BR Plus recommendations. Once recruited, those midwives will initially be utilised to increase the headcount in the three continuity teams and thus increase the percentage of women who receive CoC throughout their whole pregnancy and postnatal. If there is no extra funding identified for the variance of 6.94wte midwives, it will not be possible to further increase in CoC teams.
5. If extra funding for the variance is secured or agreed then the second phase will be commenced in the Autumn 2022 (with the newly qualified midwives) when CoC will be offered to women in Weymouth and Portland. At this point more than 50% of women will be booked on a CoC pathway
6. The third phase, if funding is secured will be in Oct 2023, commencing a review the establishment and how successful recruitment has been. If recruitment has been successful with further funding identified and secured, then the required midwives for more CoC teams will be employed and the final two teams established – one in the Dorchester area and one in Bridport and Beaminster.
7. At all times, the maternity unit will require a core staff of a supernumerary band 7 midwife coordinator and 4 midwives to ensure safety and mitigate for sickness within the CoC teams, for women who are very complex and for those who are not on a CoC pathway. It will also be essential that the ANDAU is staffed with two midwives and an MSW.
8. We intend to undertake an evaluation at each phase to check that all our systems and processes work as per plan. We also want to observe if there are any emerging patterns such as a reduction in foot fall in postnatal ward/triage etc. We want to check there are no unintended consequences.

Communication and engagement plan

As a relatively small maternity service, communication about the CoC has been managed by regular staff meetings and some 1:1 meetings as required. Enthusiasm for CoC from midwives has been heartening. This has been achieved by working with staff to ensure they do not feel coerced into working in a manner that does not suit their work/life balance. Reports from midwives in CoC teams, has been positive and this has strengthened the case. However, two midwives have asked to leave CoC teams due to too much community work and not enough intrapartum experience – this request was supported. The lead midwife for CoC (funded by the LMNS) has also engaged regularly with midwives, providing reassurance and explaining the practicalities.

Skill mix planning

1. Preceptorship midwives will be placed within the CoC teams dependent on where the midwife lives and the hours s/he wishes to work. At times this will inevitably result in some teams having a larger number of preceptors. The preceptors will be supported by the Preceptor Lead Midwife and the band 7 lead midwife for the team
2. Midwives working in the core team will be supported and line managed by the Labour Ward Lead Midwife
3. There will be appropriate and planned use of MSW particularly in teams working in areas of greatest need. The MSWs working in the CoC teams currently are a very valuable resource and report feeling valued and integrated within the team.

Training

Extra training was not required as DCH midwives work in integrated teams so are familiar with working across the community and in the maternity unit

Linked Obstetrician

- There is a linked obstetrician for the Cranberry Team. His antenatal clinic is attended by a Cranberry midwife.
- There is a link obstetrician for the Cygnet team for women who choose a homebirth outside of national guidance
- There is a linked obstetrician for the Maumbury Team. Her clinic is part of the Perinatal Mental Health MDT
- However, many women requiring obstetric input need a specialist service and this is prioritised over continuity to ensure the best advice is provided so women can make an informed decision about their care. We have the following specialist clinics
    1. Multiple Pregnancy
    2. Preterm Birth
    3. Diabetes
    4. Medical Disorders
    5. Perinatal Mental Health

Standard operating Policy (SOP)

1. The SOP provides assurance around roles and responsibilities. It is currently being reviewed by interested parties

Midwifery Pay

No midwife should be financially disadvantaged for working in this way and currently at DCH levels of pay have been maintained. The integrated model of working at DCH means that midwives are familiar with contributing to an oncall service and working regularly in community and in the hospital. The RCM and RCN are involved in discussions about further CoC models.

Estate and equipment

1) The Cranberry Team are located in Blandford and Sturminster Newton. The Cygnet Team has an office on the Maternity Unit.

2) New CoC teams will be located in the same building as the current teams. Therefore no new estate is anticipated 3) Each midwife working in a CoC team requires a smartphone and an ipad. However, as the current work pattern requires the majority of midwifes to work in community and in hospital, this equipment is in use. New members of staff (an increase in establishment) would require this IT equipment and this would be factored into recruitment.
Review Process
1. Quarterly review at board for assurance and escalation. Oversight via LMNS and region for assurance. This includes linkage with the Maternity Incentive Scheme and appropriate monitoring of KPIs through the Quality Committee and the Board.

Meeting Title:	Quality Committee / Board Meeting
Date of Meeting:	18th January 2022 / 26th January 2022
Document Title:	**Maternity Education and Training report 2021**
Responsible Director:	Nicky Lucey, CNO
Author:	Nicky Trent, Practice Educator Lead Midwife for Jo Hartley, Associate Director of Midwifery & neonatal Services

Confidentiality:	
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**

Purpose of the Paper								
	Note	✓	*Discuss*		*Recommend*		*Approve*	✓
Summary of Key Issues	• This is the first of this annual report, summarising the training provided for 2021 for all staff associated with the maternity service, including attendance percentages and plans for training and education for 2022							
Action recommended	The Trust Board is recommended to: 1. **NOTE** the report 2. **APPROVE** the contents							

Governance and Compliance Obligations

Legal / Regulatory	Y	MDT training is one of the priorities for Maternity Services, highlighted in the Ockenden Report (dec 2020)
Financial	Y	HEE have released funding for Maternity Training that is ring-fenced. This has been utilized in the past for training provision and we will continue to do so.
Impacts Strategic Objectives?	Y/N	
Risk?	Y	It has not been possible for al staff to attend all training required, due to pandemic restrictions, staff sickness and isolation requirements
Decision to be made?	N	
Impacts CQC Standards?	Y	As above
Impacts Social Value ambitions?	Y/N	
Equality Impact Assessment?	Y/N	
Quality Impact Assessment	Y/N	

Dorset County Hospital
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INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

Maternity Service

TRAINING REPORT

October 2021 – December, 2021

INTRODUCTION

Staff training at Dorset County Hospital Maternity Service has been set as per national guidance and recommendation. This consists of mandatory MDT PROMPT (Practical Obstetric Emergency Procedure Training), K2 perinatal training programme plus additional monthly hourly CTG case reviews and learning. All trained staff should attend at least one session, preferably two per year.

The labour ward coordinators, homebirth team and trained staff on SCBU should also attend four yearly a Newborn Life Support (RCUK) accredited course. All midwives attend a yearly update on newborn life support and transition as part of their mandatory essential skills day. This is also included in PROMPT as a practical demonstration and scenario.

During the last 2 years all midwives have been allocated to attend DCH Saving Babies Lives Study day which includes presentations and interactive sessions on the 5 elements as set out by SBLv2 (Saving Babies' Lives v2). This course has been open for maternity support workers, student midwives and obstetricians to attend.

The Homebirth team attend yearly to twice yearly Obstetric Emergency Training in the Community which is a half day practical simulation day together with additional training. This year, the training included how and when to perform an episiotomy. Where workload allows, staff from SWAST have joined this training day.

PROMPT

Practical Obstetric Emergency Procedure Training (PROMPT) is held monthly for the Multidisciplinary Team on the maternity unit, DCH. This is mandatory, yearly training run by 2 practice development midwives, 3 supporting midwives, anaesthetists, an obstetric consultant, a resus simulation trainer and ANNP (advanced neonatal nurse practitioner). All members of the faculty having taken the PROMPT Train the Trainers course at the PROMPT Maternity Foundation or had cascade training locally.

PROMPT faculty meetings continue to occur three monthly to review feedback, agree changes in training that reflects local and national guidance, in line with NICE and RCOG and review the effectiveness of training. Adaption of presentations, format and scenarios is ongoing alongside local risk reviews and learning outcomes. Recently, the presentations and scenarios focusing on Sepsis, Eclampsia and Postpartum Haemorrhage/Massive obstetric haemorrhage have been reviewed and enhanced in relation to recent incidents.

Minutes of the meeting and actions identified are shared within the team and Associate Director of Midwifery & Neonatal Services. Attendance is recorded on the education training matrix and reported to the Quality Committee and to the LMNS Safety Group.

FACILITATION DURING COVID-19 has continued face-to-face with smaller groups for the simulation sessions ensuring face masks are worn and hand hygiene and cleaning of equipment used between scenarios. Windows are open for ventilation and staff are expected to have taken a recent LFT and told not to attend if they have any symptoms of COVID. (as per Trust guidance). Currently, no more than 20 staff are allocated to attend, in total.

STAFF ALLOCATION: It is envisaged that there are at least 8 midwives, 2 or 3 members of the obstetric team, 3 anaesthetists, 3 theatre staff, 2 or 3 MSWs, together with student midwives and medical students if space allows, on each day. This enables the day to be as realistic to our everyday working MDT and aids team building and communication.

Challenges have occurred with allocating obstetricians and registrars/SHO's due to other rota commitments. This has proven challenging on the day to provide effective training and has been highlighted in the feedback received. It is important that faculty are allocated to the full day of training to give lectures in the morning and take part in scenarios and setting up the sessions and to ensure the smooth running of the day. There have also been dates this year where allocation of faculty midwives has been difficult due to workload commitments and there have been occasions when training has been cancelled due to staff sickness and vacant shifts. However, an extra session was put on before Christmas.

PROGRAMME:

08.30-08.45	Introduction	Lecture Theatre - All Team	
08.45-09.15	PPH/MOH	Lecture Theatre	
09.15-09.45	SEPSIS	Lecture Theatre	
09.45-10.00	COFFEE		
10.00-10.30	PET	Lecture Theatre	
10.30-11.00	MATERNAL COLLAPSE/ANAESTHETIC EMERGENCIES	Lecture Theatre	
11.00-13.00 30 minute Skills Drills/SIM Green/Pink Yellow/Orange	Pool evacuation Cord prolapse	Green/Pink Yellow/Orange	Shoulder Dystocia

13.30-14.00 2 x 15 mins	Resus equipment training	Communication Exercise	
Green/Pink Yellow/Orange	Maternal Collapse	Green/Pink Yellow/Orange	Sepsis
Green/Pink Yellow/Orange	Breech	Green/Pink Yellow/Orange	Newborn Life Support

14.00-16.20 30 minute SIM Green/Pink Yellow/Orange	Massive obstetric haemorrhage	Green/Pink Yellow/Orange	Eclampsia

16.20-16.30	Feedback and Certificates - All Team

ATTENDANCE

Training	**Staff grade**	**Percentage of attendance**
PROMPT (Practical Obstetric Emergency Procedure Training)	**Obstetric Anaesthetists**	85%
	Obstetric Consultants	100%
	Doctors (Reg/SHO)	76%
	Midwives	76%
	MSW	59%

Anaesthetists: 17/20 (85%) of staff who regularly do obstetric sessions attend PROMPT (or facilitated on it). Of the other three, 2 had to cancel due to sickness/ clinical pressures

and are reallocated in January, and the other is a trainee who arrived in August and is booked early 2022.
Other anaesthetists who might be required to attend maternity (including oncall consultants and starred consultants) - 9/18 have been trained this year and the rest allocated for 2022 (unfortunately a few had to cancel recently due to clinical pressures).
3 trainees who have arrived in the last few months but are not doing obstetrics on calls yet are allocated soon

Obstetric Registrars: 7/8 have completed PROMPT in 2021. The remaining started in the Autumn and is allocated to attend in March 2022.

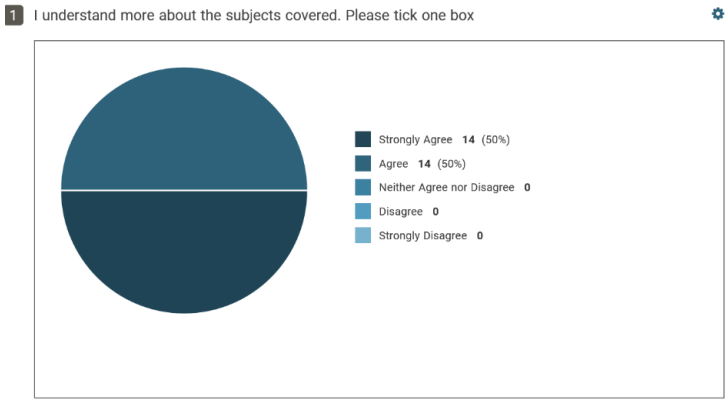
SHOs and F1 and F2: 2/5 have attended, three have joined the team in the last month and are allocated at the beginning of 2022 along with another new SHO.

Midwives: Midwives have been unable to attend due to sickness, isolating or have not been able to attend due to staff shortages and other work commitments. They will be allocated early 2022.

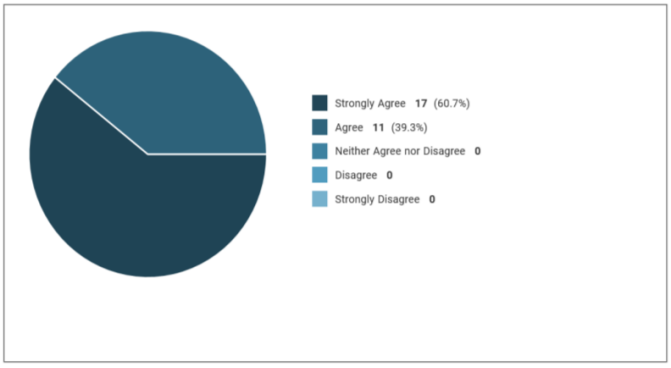
MSWs: Some of the MSWs that have not attended PROMPT have attended an MSW Training Day which includes: deteriorating patient, observations and escalation and a scenario of postpartum haemorrhage. In 2022 we will be covering Sepsis/signs of infection with them. We aim to allocate the remaining MSW's that haven't attended PROMPT by spring.

FEEDBACK

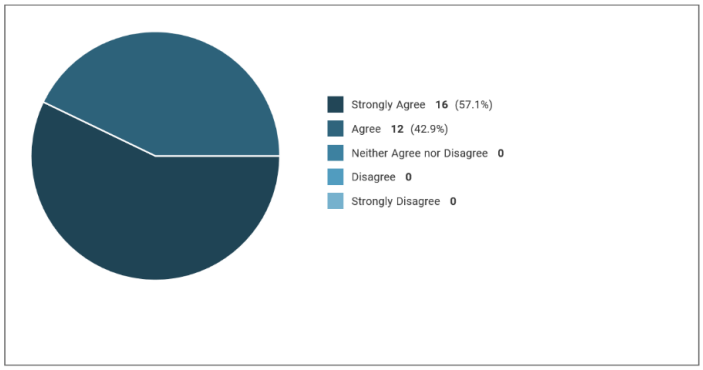
Since July, 2021 feedback has been recorded via an online Trust survey. This remains under review as since its introduction, the response has been poor in comparison with the staff feedback was via paper copy. A summary is shown below



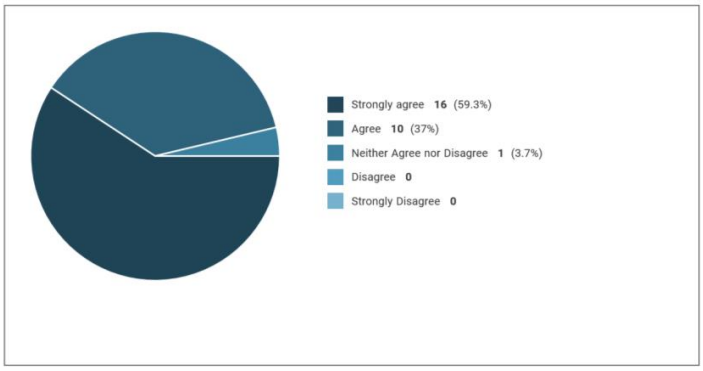
2 I found the simulations and debrief useful. Please tick one box



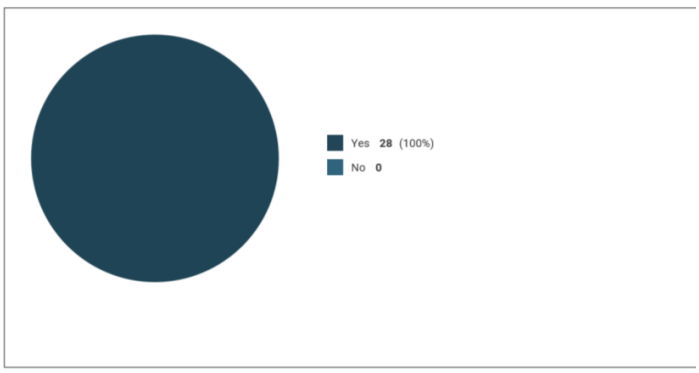
3 I have more confidence to deal with these subjects. Please tick one box



4 The material covered was relevant to me. Please tick one box



5 Does attending today have a positive effect on patient safety?



6 Please write down one thing that you have learned today that you will use in your clinical practice.

Showing all 28 responses Show less	
The importance of communication	792547-792538-83767915
Renew ALS certification Review of LA toxicity treatment	792547-792538-83767977
Lactate levels	792547-792538-83768017
Methyldopa can cause post natal depression	792547-792538-83768028
More streamlined manoeuvres for shoulder dystocia and breech .	792547-792538-83767916
That we are no longer concerned with a rise in BP since booking, unless it is over 140/90.	792547-792538-83768218
Management of PPH/MOH	792547-792538-83768372
attending emergency scenarios in the future.	792547-792538-83768538
Manual uterine displacement in CPR on maturity patients	792547-792538-83768086
More around the risks of vaginal breech birth - cord compremise, concealed bleeding etc.	792547-792538-83768440

Where the emergency equipment and medication boxes are stored.	792547-792538-83768493
Always let the woman know and partner what is going on, make the woman feel safe and re-assured, always use work colleague names when asked to get specific items in an emergency , listen and look whats going on and wait to be told what to do.	792547-792538-83768175
Simplified manoeuvres for shoulder dystocia	792547-792538-83772491
communication	792547-792538-83817429
Taking 10 seconds out during crash calls to reassess. Management of common obstetric conditions.	792547-792538-85976334
Existence of various emergency boxes and their location	792547-792538-85976462
That women shouldn't have a seizure if they are on Mag sulh which means you should look for another cause	792547-792538-85976434
Better communication with teams	792547-792538-85976604
Epis's are 60 degrees - always more than you think	792547-792538-85976594
Value of team work	792547-792538-85988663
Helping with the positioning of legs in shoulder dystocia	792547-792538-85992390
[illegible]tion	792547-792538-87004738
effective communication	792547-792538-87005835
Exaggerated SIMS position with a lowered head tilt is the recommended position now for a cord prolapse	792547-792538-87005267
The new guidance to ensure all instrumental deliveries are given 1 dose of ivabx 3 hours from delivery	792547-792538-87038998
Breech delivery on all fours	792547-792538-87183055
Finding out where everything was on the ward	792547-792538-87222545

View this response in detail

e/792547-792538-85976462

7 How could this course, or the Maternity service, be improved? Please tell us your ideas.

Showing all 17 responses Show less

More obstetricians. More people giving lectures	792547-792538-83767977
Much prefer new structure of course since covid changes, much better in smaller more relaxed groups	792547-792538-83768028
Using BadgerNet within the day would be useful.	792547-792538-83767916
Provide a prompt slides/ notes for trainees involved in the day	792547-792538-83768372
Small groups for scenarios is good. I feel many things learnt are not common practise and not commonly seen on ward. IE using the prepacked boxed for emergencies, I worked here for 6 weeks before knowing of their existence.	792547-792538-83768086
The scenario split across lunch (pre/post) felt a bit midwifery focused and then whole team focused. Maybe mix them up? appreciate this may not be possible with logistics. Very very good PROMPT course.	792547-792538-83768440
Regular MDT training, half day updates maybe.	792547-792538-83768493
Was asked to get ressus trolley brought it back but didn't realise I had to bring defibrulator back too ,	792547-792538-83768175
I feel that PROMPT has already been improved by working in smaller groups. I felt more relaxed and comfortable and not judged therefore a much better atmosphere for learning.	792547-792538-83772
it would be great if we can incorporate using an ipad and badgernet on the training days so we can practice filling out the emergency forms in real-time.	792547-792538-83817
Unsure. very useful and informative course.	792547-792538-85976
Any more hands on is always useful	792547-792538-85976
Over 2 days would be better - too much in one session	792547-792538-85976
To allow more time, discuss more topics, if the course in 2 days will be really more useful.	792547-792538-85988
Morning info was sped through quite quickly for those with less knowledge and at times difficult to keep up with . With so much to fit in maybe end later but have another short drink break . Really interesting to see the various maternity emergencies . Helps those who aren't normally in the department to know where some important things are and what else to find out about .	792547-792538-85992
It was a much better way to learn the scenarios in smaller groups. I felt more confident to speak up because of the small group and feel I learnt more. Please don't change it back to large groups ☺	792547-792538-87004

2022 Structure and Programme plan

The PROMPT 2022 programme is to be finalised at the next faculty meeting on 12th January, 2022. At our last meeting, we discussed the inclusion of COVID management within a sepsis scenario. We will be basing the scenario on a recent incident at DCH. We will also include uterine rupture/VBAC (vaginal birth after caesarean) within a new MOH scenario and include the use of cell salvage within the MOH lecture as this has been highlighted as training required by theatre team. We plan on rolling out the same scenarios for the year so that all candidates receive the same information and training which has been developed according to the recommendations of the Core Competency Framework.

During the next three years we plan to include other recommendations within the training day and base these on local events and learning that has been highlighted through risk management. Staff have felt the smaller groups during the scenarios have aided learning and are less stressful therefore these will continue.

Use of the digital maternity system, BadgerNet has already been incorporated within a couple of the emergency scenarios on PROMPT to aid learning on the system and incorporate use of tools and guidance within the system.

NEWBORN LIFE SUPPORT (NLS)

Newborn Life support (RCUK) accredited course is a mandatory requirement four yearly for Level 7 midwives, homebirth midwives and qualified staff on SCBU. During the COVID pandemic there has been a shortage of course availability as this is a face to face course and we do not facilitate the course at DCH. However, in spring 2021 an NLS instructor who works as an ANNP on SCBU rolled out a 7.5 hour day to include much of the content, demonstrations and practical skills that are included on the NLS day so that staff that were unable to get places could attend and keep updated with current guidelines and practical skills. All appropriate SCBU staff were allocated and midwives that were going to be out of date in 2021.

In 2022, we have allocated places on external courses, but there have been cancellations already due to the ongoing pandemic. We are currently actively seeking further providers.

ATTENDANCE

NLS (4 yearly accredited course)	**Senior Midwives/Homebirth Midwives**	96%

One midwife has been unable to attend due to long term sickness.

NLS (yearly update)	**Midwives**	81%

However, **93**% of midwives that, as part of their job role should attend NLS yearly update, did attend either the PROMPT NLS 30 minute scenario and demonstration or the 75 minute session on the update day.

During 2021 we have had to cancel or remove staff from the training due to staff shortages and as there are only 11 dates within the year, we have been unable to reallocate within the year. The remaining staff to be trained will be allocated in Jan, Feb and March 2022.

K2 PERINATAL TRAINING PROGRAMME

All Obstetric consultants and trainees and midwives are required to undertake the K2 programme covering intrapartum/antenatal CTG, Intermittent Auscultation (IA), fetal physiology and cord gases yearly K2 Medical Systems™: PTP Perinatal Training Program (k2ms-university.com). This is competency assessed and certified by the K2 training programme. All staff are expected to complete the remaining emergency modules prior to attending the PROMPT course but this is not included in the percentage of attendance.

ATTENDANCE

K2 Fetal Monitoring	**Doctors (All grades)**	85%
	Midwives	94%

2 doctors have not attended out of 14 and the remaining 6% of midwives who have not attended have been sent a reminder.

The Fetal Monitoring lead Midwife and lead Consultant also provide online, interactive training multiple times a month. This is an interactive discussion/learning session for midwives, consultants, trainees and students to attend as and when they can. It is expected that they attend at least 2 per year.

In 2021, 95% of midwives that need to attend have undertaken 1 session and 72% have undertaken 2 sessions. 54% of doctors have attended 1 session. This is due to other work commitments, shortness of staff and unavailability when the sessions are rostered.

FEEDBACK

Overall, feedback from the CTG sessions is excellent. They allow time to reflect on local cases, learn from events and provide important feedback and review of both patient care and decision making at the time of the event, in a safe learning environment.

K2 has been used in DCH for many years and although the programme is lengthy and many of the courses are repeated, they are research based and include up to date information and guidance on current recommendations. As the system is online, this does mean that staff can access at home, this enables them time to complete the package (approximately 9 hours) for which they get a day in lieu.

OBSTETRIC EMERGENCY TRAINING IN THE COMMUNITY

This training has been held 4 times throughout 2021. Due to COVID it has been held in the Midwife Led Unit at DCH rather than in someone's home as per previous years. One of the half day sessions was also attended by 3 members of SWAST, who are invited to each session. . Due to numbers within the homebirth team, the group has been split with the aim

that all the team can attend two sessions so that all the emergency scenarios can be covered.

This year we included how to perform an episiotomy correctly and when/why it should be performed. This was a recommendation from a review of a case by HSIB and was also included in PROMPT training.

The training provides valuable time to reflect, learn and problem solve, especially useful when an ambulance and the crew are available to practice transferring a woman and/or her baby into hospital.

The training is facilitated by the Practice Development Lead Midwife and one of the PROMPT faculty members. A practical demonstration of breech birth, shoulder dystocia and newborn life support is provided. This is followed by a scenario where the team of two midwives at the birth would practice the procedures and arrange transfer of the woman and her baby. Good use of communication and practical skills as well as documentation is reiterated to ensure safe life-saving manoeuvres and procedures are utilised appropriately and effectively.

ATTENDANCE

All the homebirth team have attended either one or two sessions in 2021. 3 members of SWAST have attended, two paramedics and one student paramedic. Four band 7 midwives were allocated but only three attended due to having to cover other work commitments.

FEEDBACK

Responses from evaluation forms, 14 returned out of 21.

What do you feel you have learnt during the session?

> Transporting neonate during resus. Importance of good communication, revision of emergency procedures and new techniques. Use of ambulance /equipment/crew. Utilising staff available. Good to discuss scenarios pertaining to homebirth and having to think outside the box.

What could have been done to improve the SiM session?

> Having paramedics at sessions. More realistic in home environment. More time.

Was the training beneficial to your practice?

> Very beneficial, particularly the practical and discussion elements. Improves knowledge & experience. Able to apply emergency skills to home environment without access to medical environment/clarified procedures in place.

ADDITIONAL TRAINING 2021

Mandatory training days at DCH for Midwives include the essential skills day –

Programme 2021

TIME	SUBJECT	RENEWABLE
08.30 – 09.30	Antenatal and Newborn Screening	Yearly
09.30– 10.30	PNMH (perinatal mental health)	
10.30 – 10.45	coffee	
10.45 – 11.15	Baby loss	
11.15 – 11.55	Epidural	Yearly
11.55 – 12.40	Fire	Yearly
12.40 – 13.10	Lunch	
13.10– 15.15	BLS	Yearly
15.15 – 16.30	Newborn life support	Yearly

Saving Babies Lives V2 study day – 08.30 – 16.30

Introduction

- Reducing smoking in pregnancy.
- Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)
- Raising awareness of reduced fetal movement (RFM)
- Effective fetal monitoring during labour.
- Reducing preterm birth.

This innovative training day was developed by Lindsey Burningham, Maternity Matron and has been rolled out over the past two years with most midwives, some of the obstetric team and some MSWs attending. Staff shortages has been one of the main reasons why people have not been able to attend. **90%** of midwives have attended and it has been well received.

Reducing smoking in pregnancy – a presentation and discussion on useful tips for starting conversations, as well as when to refer into the service. A review of guidelines and both local and national statistics. Presented by a member of the Smoking Cessation Team at DCH.

Fetal growth Restriction – Presentation and discussion on current guidelines and recommendations, information on causes, prevention and the value of ultrasound and dopplers for aiding midwives to make plans of care and referrals when relevant to consultants. We also address how to correctly measure symphysis fundal height. Presented by Midwife Sonographer

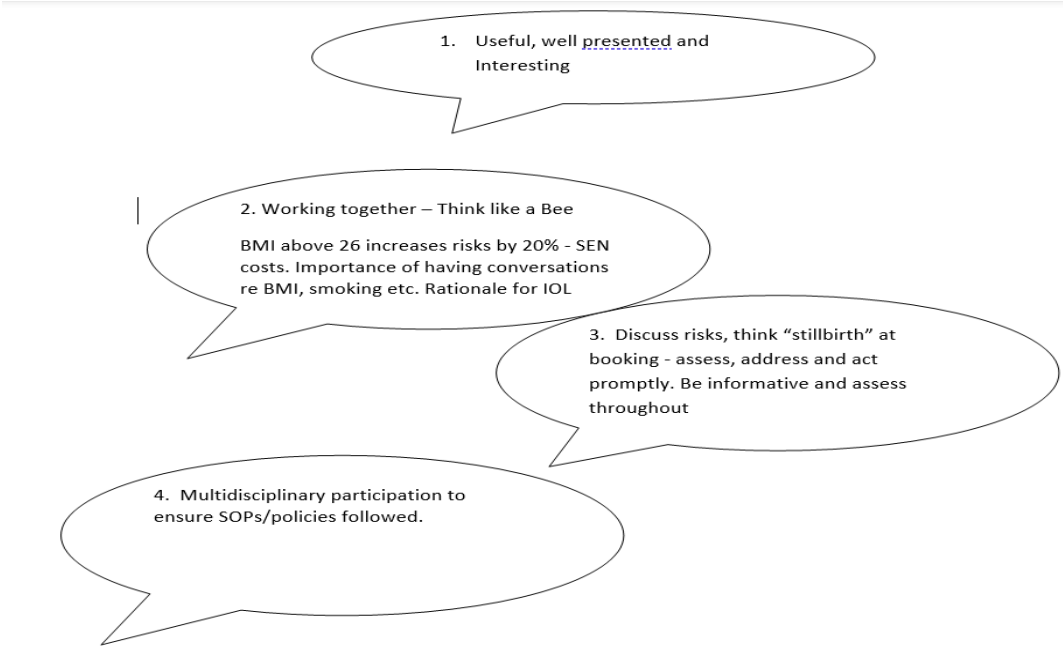
Reduced Fetal Movements – Presentation on statistics, local guideline and policies in place at DCH The national Kicks Count team have also contributed to the session – in person and more recently, virtually. There is discussion on the importance of effective communication with service users and ensuring there is information available in multiple languages to ensure correct information is given and understood. The session is presented by the Labour Ward Lead Midwife followed by presentation by CEO of Kicks Count.

Reducing Preterm Birth – Local and national statistics on preterm birth, risk assessment to predict, prevent and prepare in order to reduce mortality and morbidity. Local guidelines and policies included to ensure staff are aware of when to refer a woman to consultant led care and the importance of antenatal screening/advice. Also, the use of steroids and Magnesium Sulphate. Presentation by ANNP and Practice Development Lead Midwife

Effective fetal monitoring in labour – Interactive session covering intrapartum CTG and intermittent auscultation using calocal casesto discuss, review and evaluate care. Presented by Fetal Monitoring Lead Midwife and Obstetrician.

FEEDBACK

Introduction



REDUCING SMOKING IN PREGNANCY

1. Useful, clear, informative and updated knowledge.

2. E-cigs are 95% safer than tobacco, vaping regarded as non-smokers, effects of COVID and smoking. Give hard hitting facts and advice.

3. Explain hard hitting facts and refer, give leaflet, discuss more frequently including in hospital/DAU. When to refer.

4. Very informative, brilliant. More useful to have specialist giving training

REDUCED FETAL MOVEMENTS

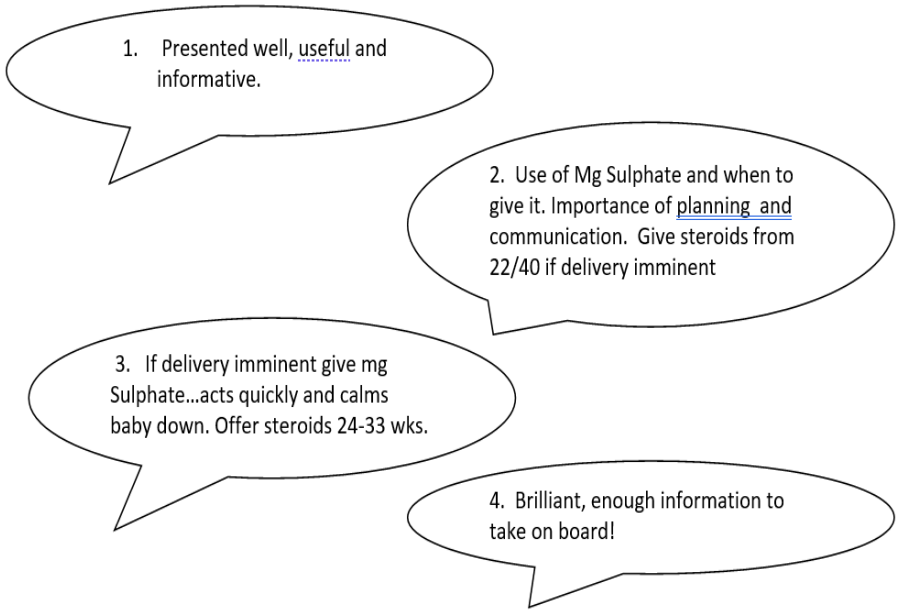
1. Informative, interesting and importance of raising awareness. RFM policy. Enjoyed Elizabeth's participation.

2. Ensure women have kicks count leaflet, advise avoid google; use NHS, Tommy's , kicks count App.

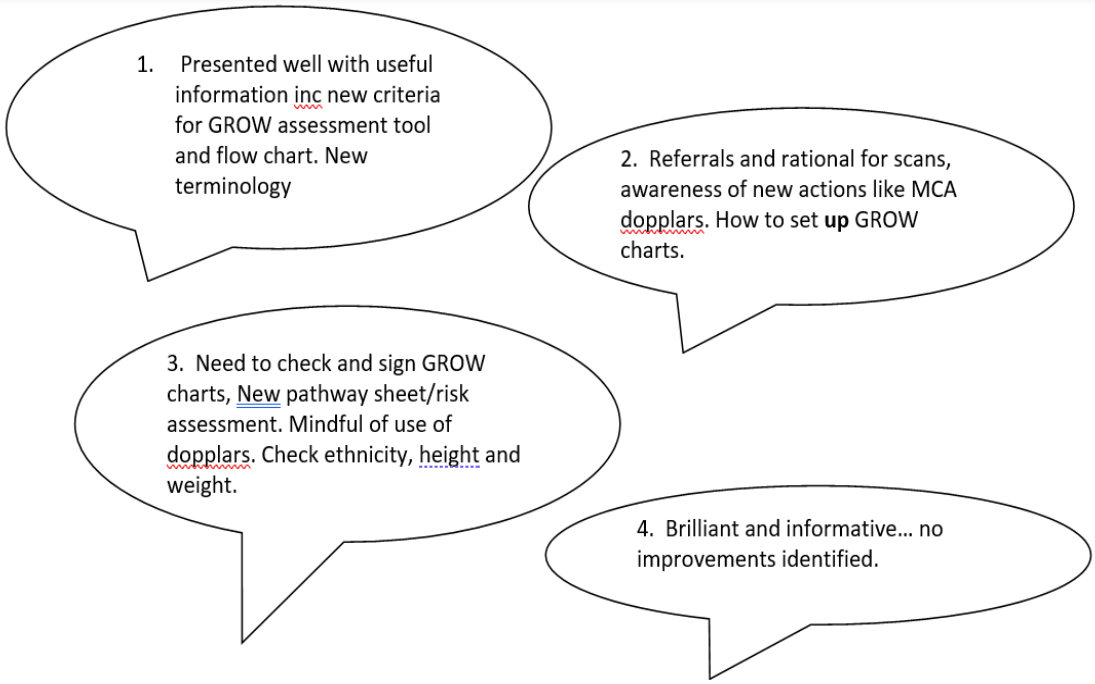
3. New posters, Information in other languages. Importance of discussing movements at every opportunity

4. Felt already updated, No improvement identified

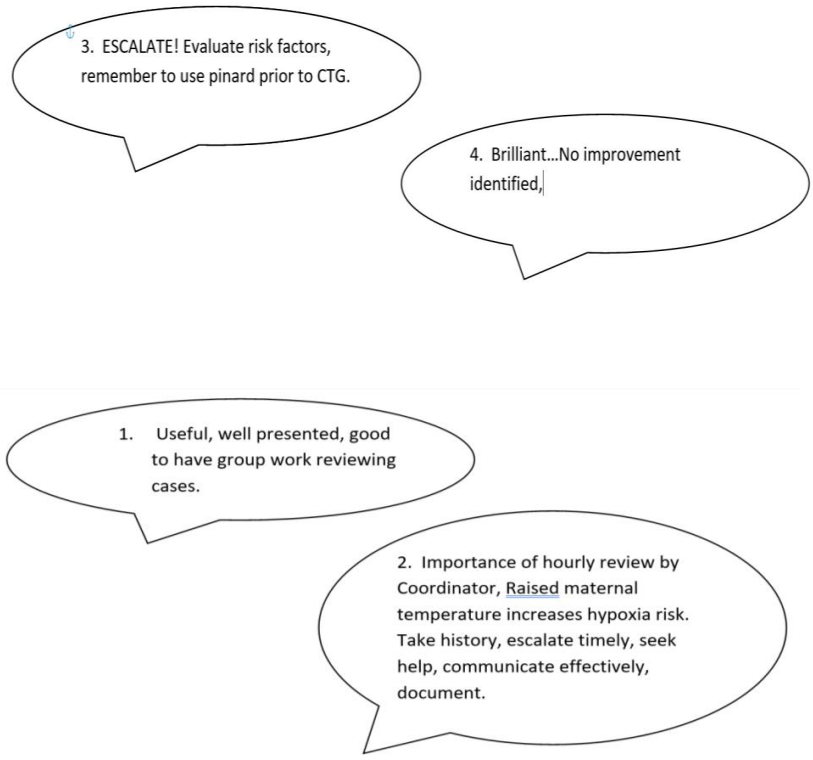
Reducing premature birth



Fetal Growth Restriction



Effective monitoring of the fetal heart



MATERNITY SUPPORT WORKER DAY

We identified that our band 2 and band 3 maternity support workers were feeling 'overlooked' in relation to training, competencies and skills. To raise morale and to address specific concerns, an updated training day was developed for the MSW's this year. The support worker managers decided it would be good for team building to join the Band 2 and 3 MSW's together. Although some of the content of the day was not as relevant to the Band 2's we felt that the information and skills they learnt would benefit their role and improve patient safety. This was also identified in the feedback.

21 MSW have attended since July 2021.

Learning Objectives:

- To improve communication and escalation
- Gain confidence to perform observations and procedures within role description
- To have a better understanding of the risks of smoking in pregnancy and what very brief advice can be given
- Learn how to take CO readings and document results
- To improve skills in record keeping/use of NEWT/MEOWS/Fluid balance charts/digital system
- Improve knowledge and confidence in providing/discussing antenatal and newborn screening and learn current guidance
- Gain confidence in supporting families with baby loss
- Gain more insight into safeguarding children/babies in order to support families and midwives on ward and in home environment. Importance of escalating concerns and who to report to
- Have a better understanding of the babies that are at risk of becoming unwell, assessing and observing babies and who to escalate concerns
- Gain confidence in when to perform blood glucose monitoring and SBR's
- To understand the importance of civility and how it improves patient safety,staff morale and confidence

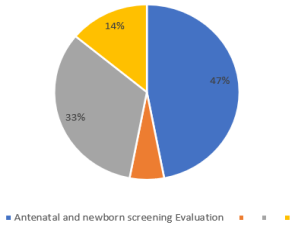
PROGRAMME

08.30 – 08.35	Introduction	Nicola Trent
08.35 – 09.05	Antenatal and Newborn screening	Janet Johns/Sophie Wilson
09.05 – 10.05	Smoking in pregnancy	Nikki Ryan/Jackie Nott
10.05 – 10.35	Baby loss/Bereavement	Claire Choak
10.35 – 10.45	coffee	
10.45 – 12.45	ATAIN – Inc bm's, escalation and NEWT chart	Kate Hopkins
12.45– 13.15	**Lunch**	
13.15– 14.00	Civility	Nicola Trent
14.00– 14.30	Safeguarding	Gerry Graham
14.30 – 16.15	Practical skills workshop/communication/escalation	Nicola Trent/Gemma Westaway
16.15 – 16.30	Evaluation and feedback	Nicola Trent

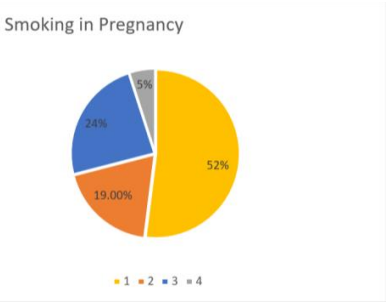
FEEDBACK

The following feedback is taken from 21 evaluations which is the total number of MSW that have completed the training day so far in 2021.

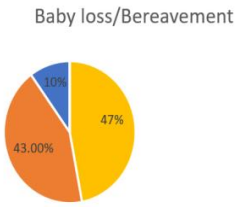
	Antenatal and newborn screening Evaluation
CATEGORIES	VALUES
Excellent	47%
Good	
Satisfactory	33%
Unhelpful	14%
MSW July 2021	
MSW Oct 2021	
MSW Nov 2021	
MSW Dec 2021	



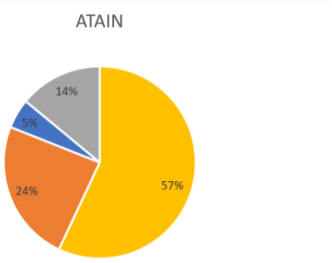
Smoking in Pregnancy	
CATEGORIES	VALUES
Excellent	52%
Good	
Satisfactory	24%
Unhelpful	5%



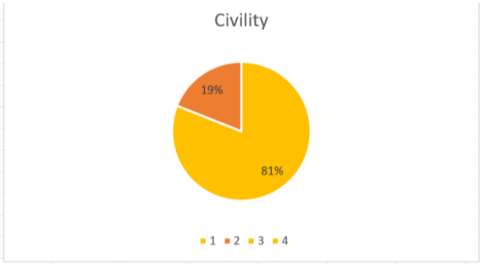
Baby Loss/Bereavement	
CATEGORIES	VALUES
Excellent	47%
Good	
Satisfactory	10%
Unhelpful	0%



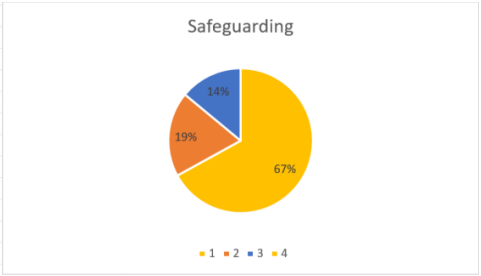
ATAIN	
CATEGORIES	VALUES
Excellent	57%
Good	24%
Satisfactory	5%
Unhelpful	14%



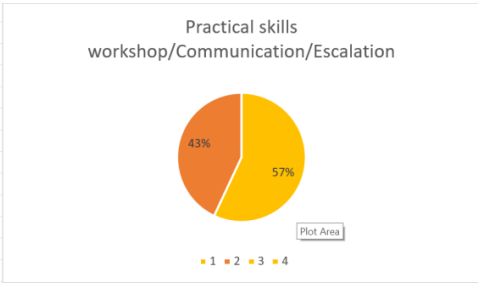
CATEGORIES	VALUES
Excellent	81%
Good	19%
Satisfactory	
Unhelpful	



CATEGORIES	VALUES
Excellent	67%
Good	19%
Satisfactory	14%
Unhelpful	



CATEGORIES	VALUES
Excellent	57%
Good	43%
Satisfactory	
Unhelpful	



ADDITIONAL COMMENTS:

Antenatal and Newborn Screening : Great for Band 3 Role.

Feel have a better understanding and refresher.

Informative but probably won't use in band 2 Role

Smoking in Pregnancy: Feel more confident. Informative and feel could undertake CO reading now.

Not really relevant for my Role

Conclusion

Overall, the MSW update and training day was well received with positive feedback. The Level 3 MSW felt that the topics covered were relevant and felt it was a good refresher. This in turn improved their confidence and will have a positive impact on patient care.

A minority of the Level 2 MSW felt that some of the sessions were not relevant to them in their current role but found the sessions interesting and informative.

They were grateful that they had a dedicated day for them.

PLAN FOR 2022

During 2022 the training for MDT will continue to be PROMPT and K2 perinatal programme. PROMPT will have new scenarios as previously mentioned.

The midwife essential skills day will include ATAIN (Avoiding Term Admission into Neonatal unit) in order to reduce the number of admissions to SCBU. Learning from Events will be added, given by the Risk management team who will bring cases of interest and learning to discuss and review.

An additional learning day will take the place of the full Saving Babies Lives study day but an update of the 5 elements will be incorporated within the day so that staff will stay up to date with current changes and guidance.

A diabetes in pregnancy update will be given by the lead Diabetes Nurse specialist to include a recap of signs and symptoms of hypo/hyperglycaemia, using variable rate infusions, current guidance, and medication in pregnancy. This has been identified as a learning requirement from the risk management team due to several datix submissions.

The physiotherapy team are presenting to try to improve the advice given for pelvic floor exercises and care and improve the referral rate for women experiencing problems following birth or who have sustained 3rd and 4th degree tears.

A session on the use of digital patient records (BadgerNet) will be led by one of the superusers at DCH to address common problems and answer questions from the group.

Mandatory supervisor and assessor training will be given by the student link lead educator and Bournemouth University lecturer to cover the new MORA system.

A member of the PMA team (Professional Midwifery Advocates) will provide a session to give advice and support and brief overview of their roles and responsibilities and when and how they can be accessed. There may be a chance for some restorative supervision but time restraints on the day and numbers of attendees would not necessarily have the desired effect for the staff.

The Homebirth team and practice development midwife plan to attend the Baby Lifeline training on emergencies in the community this year which we will cascade any learning into the local training at DCH.

Newborn Life support courses will be allocated as per whom is out of date and will commence end of February as courses become available.

Two new members of staff are to join the practice development team working one day per week each. It is envisaged that one will oversee the MSW training. A further Obstetric consultant is joining the PROMPT faculty in February who has facilitated the course before. This should ensure that there is Obstetric faculty cover on each day.

All staff will be allocated to training according to when they last updated to ensure they remain in date as much as possible.

The maternity service is working towards BFI (Baby Friendly) accreditation and each midwife and Band 3 MSW will undertake two full days training within the next 18 months and the Band 2 MSW will undertake one day.

Further digital patient record training will take place throughout the year as will the CTG monitoring interactive sessions.

Meeting Title:	DCHFT Board
Date of Meeting:	26th January 2022
Document Title:	**DCH Charitable Funds Committee: Terms of Reference (updated)**
Responsible Director:	Nicholas Johnson, Deputy Chief Executive
Author:	Simon Pearson, Head of Charity & Social Value

Confidentiality:	
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
DCHC Governance Working Group Charitable Funds Committee (CFC)	October 2021 3.11.21	CFC reviewed the updated Terms of Reference for the committee; and recommend these to Board (Corporate Trustee) for approval.

Purpose of the Paper	For Board to approve the updated Terms of Reference for DCH Charitable Funds Committee.							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	The DCH Charitable Funds Committee Terms of Reference have been updated as part of DCH Charity's Governance review. • DCHC Governance Working Group have reviewed/updated the Terms of Reference to reflect DCH Charity's current operational activities, composition of the committee and current charity governance requirements. • Clinical Representative will now be required 'in attendance' at committee meetings (ie. CNO or CMO or a deputy) – to advise on clinical matters relating to charitable funding and the charity's fundraising activities. • Financial limits and authorisations remain unchanged, as per DCH Charitable Fund SFIs. • Reporting: An Escalation Report (not full minutes) will be submitted to the Trust Board following each committee meeting and will be presented by the Committee Chair. • DCH Charitable Funds Committee have reviewed the updated Terms of Reference and recommended them for approval by Board (Corporate Trustee)							
Action recommended	The Trust Board is recommended to: 1. **APPROVE** the updated DCH Charitable Funds Committee Terms of Reference.							

Governance and Compliance Obligations

Legal / Regulatory	Y	Charities Act 2011 (NB. New Charities Bill currently 'in passage'.)
Financial	Y	As per DCH Charitable Fund SFIs.
Impacts Strategic Objectives?	N	
Risk?	N	
Decision to be made?	Y	To approve updated CFC Terms of Reference.
Impacts CQC Standards?	N	
Impacts Social Value ambitions?	Y	DCH Charity contributes to DCH social value commitments as per DCHFT Social Value Pledge.
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

TERMS OF REFERENCE

DCH CHARITABLE FUNDS COMMITTEE (CFC)

1. Membership

Chair: a nominated Non-executive Director
Two further nominated Non-executive Directors
Chief Finance Officer
One further Executive Director

Additionally, because of the unique position of the Trust Board being the sole Corporate Trustee* of the charity, all Trust Board members may attend any or all Charitable Funds Committee meetings in a voting capacity and will be provided with agendas (Only agendas will be issued. Any agenda supporting papers required are to be requested) and minutes of meetings at appropriate times.

** The Charity Corporate Trustee is the Board of Directors of Dorset County Hospital NHS Foundation Trust. Members of the CFC are nominated by the Board. Individual members of the Board of Directors and the Charitable Funds Committee are not individual Trustees under Charity Law but act as agents on behalf of the Corporate Trustee.*

2. In attendance

Head of Charity
Finance Representative
Head of Governance
Clinical Representative (CNO or CMO or a deputy)
Governor observers (up to 3 Governors)

2.1 The role of the Clinical Representative will be to inform clinically-related discussions in order to assist the agents acting on behalf of the Corporate Trustee to make their decisions.

2.2 Other members of Trust staff, including other Directors, may be invited to attend to present and/or discuss particular items on the Agenda.

2.3 The Head of Charity or their nominee shall act as Secretary to the committee.

Deputies

2.4 Members cannot nominate deputies to attend committee meetings in their place due to the status of the Trustee role.

3. Appointment of Committee Chair and Members

3.1 The Trust Chair shall decide which Non-executive Directors will be most suitable for nomination as Chairs and/or members of each committee. The Board of Directors shall approve the appointment of the committee Chair and Non-executive members, based on the Chair's recommendations.

4. Purpose

4.1 The purpose of the committee is to:

a. Provide strategic direction in determining and safeguarding the mission and vision of the charity;
b. Ensure that the charity is managed and administered properly and that the assets of the charity are protected and enhanced;
c. Oversee the operation of the charity and its transactions and the management of the investments owned by the charity;
d. Seek assurance that the charity is operating in accordance with relevant legislation and with the regulations associated with its registration with the Charity Commission.

5. Duties

a. Specific Duties

- Oversee:
  - the operation of the charitable funds to ensure they are managed and operated in accordance with their governing documents and comply with relevant legislation and guidance from the Charity Commission.
  - review and monitor the effectiveness of all fundraising activities and developments.
  - compliance with the Trust's Standing Financial Instructions and Scheme of Delegation.

- Receive:
  - reports detailing the establishment of new funds for approval.
  - reports detailing balances of the charity's funds.
  - reports on all individual charitable non-pay transactions in excess of £10,000.
  - internal audit reports on the charity's internal controls.

- Approve:
  - all new staff appointments made from charitable funds.
  - expenditure of all individual charitable non-pay transactions valued between £25,000 and £100,000 (where there is an urgent requirement for an order to be placed, the equivalent of a quorum may give approval by email, and ratified at the next committee meeting).

- Review:
    - the spending plans and balances held within individual charitable funds.
    - the impact on the charity of changes in legislation both of a charitable and non-charitable nature ie. Charity Commission, Statement of Recommended Practice (SORP), Governance Code and make appropriate recommendations to the Trust Board, as Corporate Trustee, as to how any new requirements will be met.

- Decide whether donations given with restrictions applied should be accepted by the charity.

- Recommend the appointment of investment managers to provide investment advice and manage the Trusts investment portfolio.

- In conjunction with the investment managers, agree an investment policy which lays down guidelines in respect of:
    - The balance required between income and capital growth
    - The balance of risk within the portfolio
    - Any categories of investment which the Trust does not wish to include in the portfolio on ethical grounds

- Determine a policy for the distribution, or otherwise, of realised and unrealised gains on losses on investments.

- Consider:
    - the charity's annual report and accounts.
    - Annually the composition of the charitable funds representatives list.

- Approve bids to the charitable funds on the following basis:

Limit	**Delegation**
Under £2,000	Deputy Chief Finance Officer or Chief Finance Officer.
£2,000 to £9,999	Deputy Chief Finance Officer or Chief Finance Officer and Chair of Charitable Funds Committee.
£10,000 +	Charitable Funds Committee (members only).
Emergency powers	The Chief Finance Officer and Trust Chair may approve expenditure in excess of CFC delegated limits for matters of urgency having contacted one other member for approval. All approvals on this basis will be reported retrospectively to the Board of Directors (Corporate Trustee) for ratification.

- Approve budget requests for funding activities of the charity

Limit	Delegation
Under £2,000	Head of Charity plus Deputy Chief Finance Officer or Chief Finance Officer.
£2,000 to £10,000	Deputy Deputy Chief Finance Officer or Chief Finance Officer.and Chair of Charitable Funds Committee.
Over £10,000 up to £100,000	Board of Directors (Corporate Trustee).
£100,000 and over	Corporate Trustee

b. Reports

The committee will receive the following reports on a quarterly or annual basis:

Quarterly Reports

- Details of the charity's six month operational cash requirements
- Summary of fund balances the spending plans and balances held within individual charitable funds.
- Details of individual non-pay transactions over £10,000 in value
- Details of funds with balances in excess of £25,000
- Details of the establishment of new funds for approval.
- Fundraising update
- Charity's Risk Register for review
- Investment performance reports

Annual Reports

- Annual Accounts and Letter of Representation signed on behalf of the charity (Recommend for approval by Corporate Trustee)
- Report of the audit of the accounts and audit opinion from the external auditor
- Annual Report (Recommend for approval by Corporate Trustee)
- Schedule of Support Costs (for approval)
- Schedule of Risk Register (for review)

c. General

- To review its own performance, Constitution and Terms of Reference on an annual basis to ensure it is operating effectively reporting on the outcome to the Corporate Trustee
- To report annually to the Corporate Trustee (Trust Board of Directors) through the production of an Annual Report and Accounts;
- To provide Escalation Report to the Corporate Trustee after each meeting of the CFC.

6. Quorum

6.1 The committee shall be deemed quorate if there is representation of a minimum of three members present at the meeting including the Chair or their nominated deputy. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the committee.

7. Authority

7.1 The Committee is invested with the delegated authority to act on behalf of the Corporate Trustee. The limit of such delegated authority is restricted to the areas outlined in the Duties of the Committee (above) and subject to the rules on Reporting, as defined below. The committee is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are requested to co-operate with the committee in the conduct of its inquiries.

7.2 The committee is authorised by the Corporate Trustee to obtain independent legal and professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary. All such advice to be arranged in consultation with the Trust Head of Governance

7.3 Committee members have delegated powers to ensure that the charity acts within the terms of its Declaration of Trust, appropriate legislation and Charity Commission guidance; and to provide assurance to the Trust Board that the charity is properly governed and well managed across its full range of activities.

8. Frequency of meetings

8.1 The Committee shall meet not less than 4 times per financial year. The Chair may request an extraordinary meeting if they consider one to be necessary.

8.2 The Committee shall have the ability to holding meetings virtually if required; in line with the operating context of the NHS which remains under tighter Covid protection and safety guidance than the wider public arena.

9. Minutes and Reporting

9.1 Agendas and papers should be prepared and circulated in sufficient time for committee members to give them due consideration.

9.2 Minutes of committee meetings shall be formally recorded and sent to the committee Chair for checking within 5 working days of the meetings. An Escalation Report will be submitted to the Trust Board at its next meeting and may be presented by the Committee Chair.

9.3 Minutes will be retained by the Head of Charity for audit purposes.

9.4 The committee should report to the Board as appropriate, to inform the Board of any issues that require resolution by the Board.

9.5 The committee will receive reports from each meeting of its sub-groups as follows:

- Charitable Funds Strategy Group
- Charitable Funds Governance Working Group
- Fundraising Volunteers Group

10. Conduct of Business

10.1 The conduct of business will conform to guidance set out in the Board of Directors Standing Orders, unless alternative arrangements are defined in these Terms of Reference.

Reviewed by CFC (3.11.21) for approval by Corporate Trustee